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Vol. 17, No. 1
January, 1968

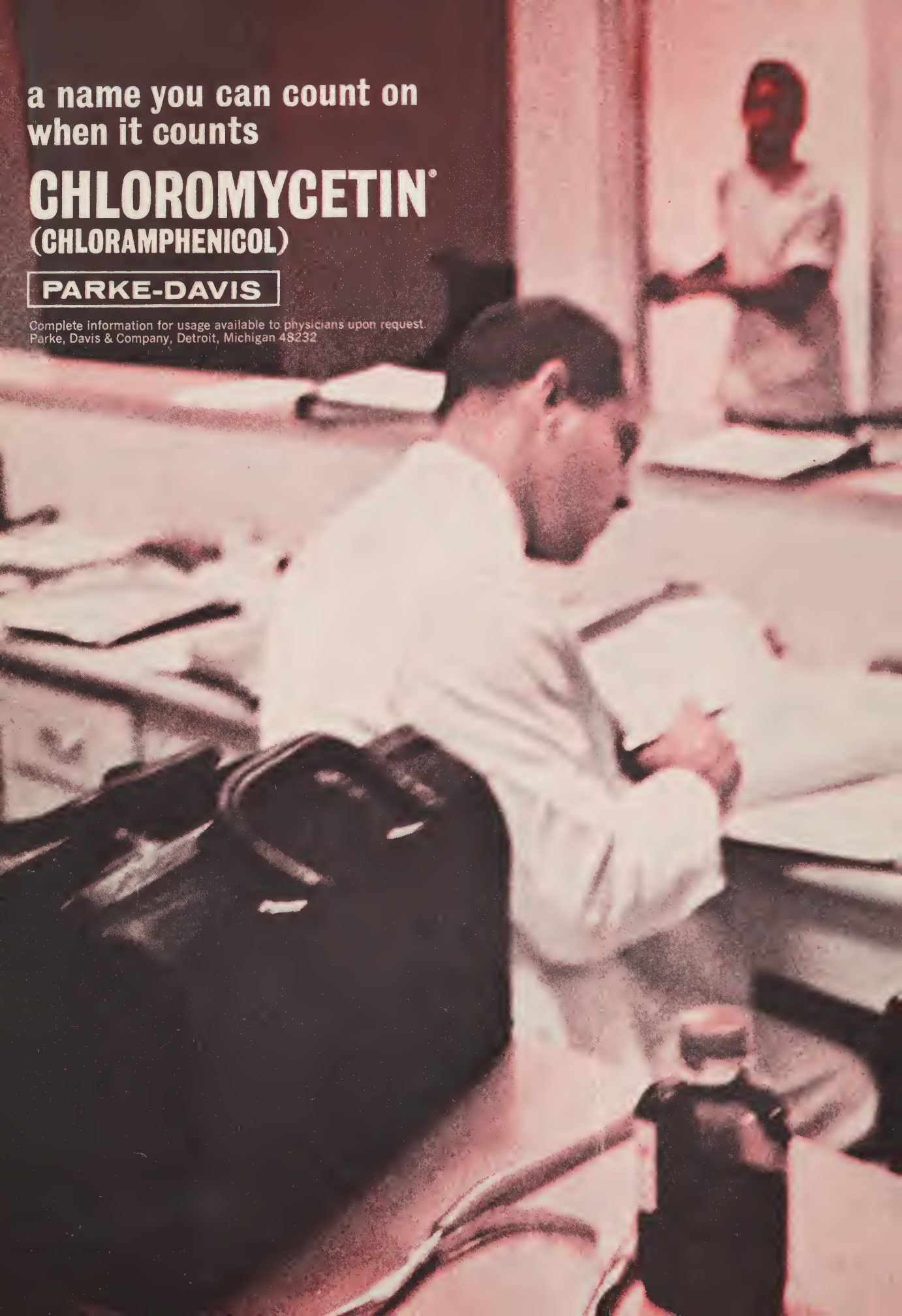
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INDEX MEDICUS

OFFICIAL PUBLICATION OF THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND


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Warning—In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions—Overgrowth of nonsusceptible organisms may occure. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth— dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm. given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Acute gonococcal anterior urethritis in males has been treated effectively with a single dose of 600-900 mg. of DECLOMYCIN Demethylchlortetracycline. Individuals unable to tolerate large single doses due to gastrointestinal side effects may be treated with 150 mg. every 6 hours for a minimum of 4 doses or 300 mg. every 12 hours for a minimum of 2 doses. Females should be treated with a dosage of 150 mg. every 6 hours or 300 mg. every 12 hours until a cure is effected.

Primary Atypical Pneumonia (Eaton Agent): The average adult daily dosage is 900 mg. in 3 divided doses for six days.

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Doctors take note...

FEBRUARY 8-14, 1968

COUNCIL ON MEDICAL EDUCATION, AMERICAN MEDICAL ASSOCIATION

Medical Education: Palmer House, Chicago, Ill. Contact: Secretary, Council on Medical Education, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610.

MARCH 10, 1968

MARYLAND ACADEMY OF GENERAL PRACTICE

Board of Directors Meeting, 11 A.M.: Maryland Room, Holiday Inn Downtown, Baltimore, Md.

MARCH 11-13, 1968

AMERICAN COLLEGE OF SURGEONS

Three-Day Sectional Meeting: Williamsburg, Va. Contact: Mr. T. E. McGinnis, American College of Surgeons, 55 E. Erie St., Chicago, Ill. 60611.

MARCH 15-17, 1968

NATIONAL HEALTH COUNCIL

Forum on current standards, methods and practices: Statler-Hilton Hotel, Los Angeles, Calif. Contact: Arthur Jack Grimes, National Health Forum Coordinator, National Health Council, 1740 Broadway, New York, N. Y. 10019.

MARCH 18-20, 1968

HAHNEMANN MEDICAL COLLEGE AND HOSPITAL

Postgraduate Course—Psychodelic Drugs: Marriott Motor Hotel, Philadelphia, Pa. Director, Paul Jay Fink, MD. Contact: Sage Rosen, Assistant Director, Postgraduate Education, Hahnemann Medical College and Hospital, Dept. of Medicine, 230 N. Broad St., Philadelphia, Pa. 19102.

MARCH 22-23, 1968

COUNCIL ON MEDICAL SERVICE, AMERICAN MEDICAL ASSOCIATION

Socio-Economics of Health Care: Palmer House, Chicago, Ill. Contact: Division of Socio-Economic Activities, Dept. of Health Care Services, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610.
(Requests for hotel reservation cards must be received before February 23, 1968.)

170th ANNUAL MEETING OF THE M

Wednesday, Thursday

Sunday, April 2

A scientific program of wide interest to physicians in all fields of medicine, as well as to house officers and medical students, has been planned by the Committee on Program and Arrangements.

The scientific sessions will begin with a **Quiz The Experts** luncheon at the Sheraton-Belvedere Hotel on Wednesday, April 17, followed by **Lectures** at the Alcazar. On Thursday morning, there will be **Medical Grand Rounds** presented by The Johns Hopkins University School of Medicine, and a lecture by Doctor Maurice B. Strauss on "Chronic Nephritis Revisited". On Thursday afternoon **Surgical Grand Rounds,** presented by the University of Maryland School of Medicine, will be followed by a lecture at the Alcazar given by Doctor Arthur M. Vineberg on cardiac surgery. The scientific sessions of this Meeting will end at Friday noon, after three lectures of great interest.

Information about recent advances in medicine will be available through the **Scientific** and **Technical Exhibits,** which will be on display at the Alcazar. Each display will be manned by someone knowledgeable in the subject. Anyone wishing to have a scientific or technical exhibit at the Meeting should communicate with the Faculty office at

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THE EXHIBITS — A WORTHY FEATURE OF THE EDUCATIONAL PROGRAM
of the
MEDICAL AND CHIRURGICAL FACULTY ANNUAL MEETING

April 17, 18, 19, 1968 **at the Alcazar**

TECHNICAL EXHIBITORS
(as of January 1, 1968)

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Hummel-Rhode & Co.
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Lakeside Laboratories, Inc.
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Smith Kline & French Laboratories and Hynson, Westcott & Dunning, Inc. are making a contribution, although they are unable to have exhibits this year.

DICAL AND CHIRURGICAL FACULTY

Friday, April 17, 18 ,19

to Sunday, April 28

once. There still may be a few booths unassigned.

As a benefit of membership, **Health Evaluation Tests** will be given again this year at the Alcazar to Faculty members and their families. These tests have become more popular each year with an ever increasing number of examinees.

An **AMA-ERF Theater Benefit** has been arranged by the Woman's Auxiliary for Wednesday evening at the Morris Mechanic Theater. The play will be the Broadway hit comedy, **"You Know I Can't Hear You When the Water's Running"** starring Eddie Bracken.

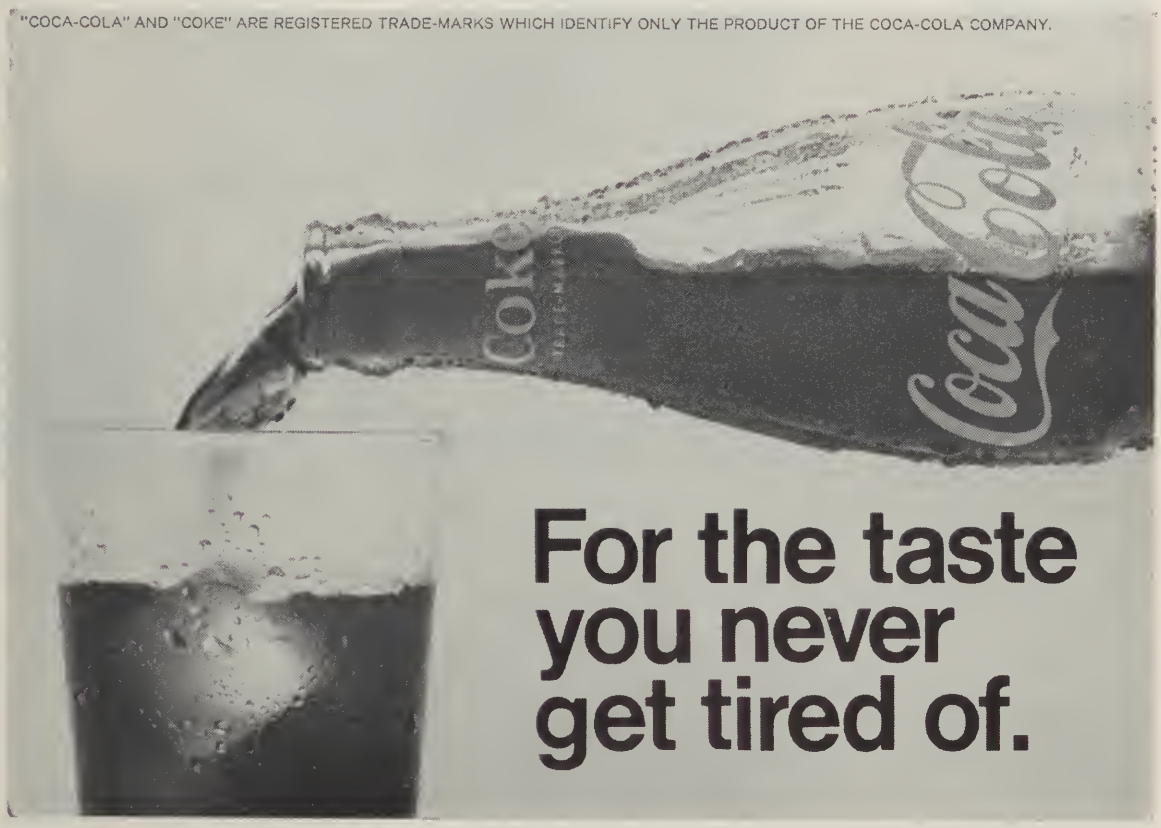
The annual **Presidential Reception and Dinner** will be held at the Sheraton-Belvedere Hotel on Thursday evening with Art Buchwald as the after dinner speaker.

The **House of Delegates** of the Faculty will meet on Wednesday morning and Friday afternoon.

The **Caribbean Cruise Convention** starts when the SS Argentina leaves Baltimore on Sunday, April 21, and will continue aboard ship and in San Juan and St. Thomas, until the ship returns to Baltimore on Sunday, April 28. There will be **daily Scientific Lectures and Films.**

ANNUAL MEETING CONTINUED ON CARIBBEAN CRUISE CONVENTION—APRIL 21-28, 1968

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TO SPEAK AT THE ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY APRIL 17-28, 1968

CIRRHOSIS OF THE LIVER: A PANORAMIC VIEW will be the title of a paper to be presented at the Alcazar in Baltimore on Wednesday, April 17, by **CHARLES M. CARAVATI, MD.** Dr. Caravati has been Professor of Medicine and Assistant Dean in charge of Continuing Education at the Medical College of Virginia since January 1966. Prior to that he was in the private practice of internal medicine and gastroenterology in Richmond, Virginia. Dr. Caravati's undergraduate training was at the University of Richmond and he received his MD from the Medical College of Virginia. Following an assistant residency at Providence Hospital in Washington, D. C., he was on a fellowship in gastroenterology at The Johns Hopkins Hospital. Dr. Caravati has served as Governor, Regent, Vice President, and is now Master of the American College of Physicians.



Dr. Caravati



Dr. Harrison

THE SURGICAL MANAGEMENT OF DISORDERS OF THE ADRENAL CORTEX is the title of the first *Albert E. Goldstein Memorial Lecture* to be given at a meeting of the Medical and Chirurgical Faculty. **JOHN HARTWELL HARRISON, MD,** will give this lecture on Wednesday, April 17. Dr. Harrison, born and educated in Virginia, interned at Lakeside Hospital in Cleveland in internal medicine and took his surgical and urological training at the Peter Bent Brigham Hospital and Harvard Medical School. During 42 months in the Southwest Pacific in World War II, the Harvard Unit had close relations with both The Johns Hopkins and University of Maryland Units. Dr. Harrison is Chief of Urology at the Peter Bent Brigham Hospital and Elliott Carr Cutler Professor of Surgery in the Harvard Medical School. He is consultant in Urology to the Children's Medical Center, Boston Women's Hospital, the West Roxbury Veterans Administration Hospital and the Lemuel Shattuck Hospital.

CHRONIC NEPHRITIS REVISITED WILL BE THE TOPIC MAURICE B. STRAUSS, MD, will discuss at the Annual Meeting on Thursday morning, April 18. Dr. Strauss will review the subject of chronic nephritis, stressing that there is a benign form which is focal in nature, gives an alarming urinary sediment, but is consistent with long life. After graduating from The Johns Hopkins University School of Medicine, Dr. Strauss interned at the Boston City Hospital and subsequently was associated with the Thorndike Memorial Laboratory at the hospital and was a member of the Harvard Medical School Faculty. After concluding his military service during World War II in the Army Medical Corps, Dr. Strauss became the first Chief of Medicine at the Cushing Veterans Administration Hospital and moved to the Boston Veterans Hospital in the same capacity when that institution opened in 1952. He was Professor of Medicine at Boston University School of Medicine from 1952 to 1966. Over 100 articles written by Dr. Strauss have been published and those in recent years have been mostly concerned with renal physiology and disease and the mechanisms by which the volume of the body fluids is kept constant. He is author of several books on water and electrolyte metabolism and is co-editor of *Diseases of the Kidney*. In April 1968 a collection of over 7,000 *Familiar Medical Quotations*, which he has edited, will be published. Since January 1967, Dr. Strauss has been Professor of Medicine and Associate Dean of Student Affairs at Tufts University School of Medicine. He is also a lecturer on Medicine at Boston University School of Medicine and Harvard Medical School.



Dr. Strauss



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When you start with economical Tetrex-F (tetracycline phosphate complex-nystatin), you can complete the full course of broad-spectrum therapy with less chance of losing control elsewhere. A good start for a healthy finish.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

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PROFESSIONAL COURTESY—

Should the time-honored custom of professional courtesy be extended without limits to all physicians and their immediate families, or should its application vary according to circumstances?

What about the psychiatrist, for example? Should he render his services without any fee whatsoever when long-range care involving one or two hours weekly of his restricted patient load is involved?

What about the obstetrician in the college town who has the wives of all medical students—a significant percentage of his practice—as his patients?

What about the ophthalmologist who is called upon to fit contact lenses for a physician's entire family?

If no fee would have been charged, had the patient been without medical-hospitalization insurance, would it be considered proper to accept insurance payments for the professional services provided?

Because of the increasing specialization in medicine and continuing changes in medical practice, the AMA's Judicial Council has been swamped with requests to clarify its position on professional courtesy.

To provide physicians with guidance on the matter of professional courtesy, the Judicial Council adopted the following opinion:

The custom of professional courtesy embodies the ancient tradition of fraternalism among physicians in the art which they share, and their mutual concern to apply their learning for the benefit of one another as well as their patients. The Judicial Council reaffirms and endorses the principle of professional courtesy as a noble tradition that is adaptable to the changing scene of medical practice.

Professional courtesy is not a rule of conduct to be enforced under threat of penalty of any kind. It is the individual responsibility of the physician to determine for himself and within his own conscience to whom and the extent to which he shall allow a discount from his usual and customary fees for the professional services he renders, and to whom he shall render such services without charge as professional courtesy.

The following guidelines are offered as suggestions to aid physicians in resolving questions related to professional courtesy.

WHERE DO YOU DRAW THE LINE?

1. Where professional courtesy is offered by a physician but the recipient of services insists upon payment, the physician need not be embarrassed to accept a fee for his services.

2. Professional courtesy is a tradition that applies solely to the relationship that exists among physicians. If a physician or his dependents have insurance providing benefits for medical or surgical care, a physician who renders such service may accept the insurance benefits without violating the traditional ethical practice of physicians caring for the medical needs of colleagues and their dependents without charge.

3. In the situation where a physician is called upon to render services to other physicians or their immediate families with such frequency as to involve a significant proportion of his professional time, or in cases of long-term extended treatment, fees may be charged on an adjusted basis so as not to impose an unreasonable burden upon the physician rendering services.

4. Professional courtesy should always be extended without qualification to the physician in financial hardship, and members of his immediate family who are dependent upon him.



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

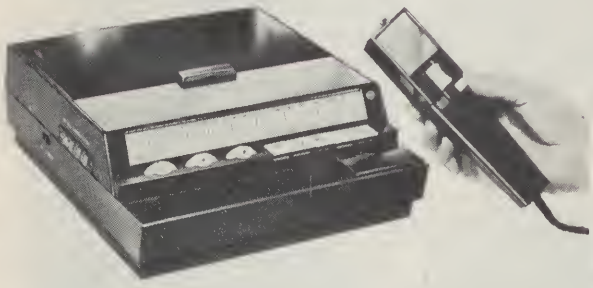
Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.



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THE PHYSICIAN'S CAREER

A NEW AMA PUBLIC

Despite the remarkable changes that have occurred in patterns of medical practice, the enormous expansion of professional and occupational resources on the allied health team and the explosive growth of community health services involved in total health care within the past generation, few changes have been made in the medical school curriculum to help prepare the new physician to grasp, appreciate and meet these accelerating socio-economic challenges once he enters practice.

As a step toward surmounting this educational void, the American Medical Association has developed a new publication, *The Physician's Career,* a 99-page handbook intended to serve as a teaching outline on medical practice and community relations for physicians and medical students.

More than two years in the making, *The Physician's Career* was the direct result of suggestions made at recent meetings of the House of Delegates that teaching outlines of informative material on medical ethics, medical civics and socio-economic aspects of medical practice be provided to medical schools and medical societies for orienting students and recent graduates to nonscientific aspects of the physician's career.

Fifteen AMA departments and a task force of staff consultants cooperated in producing *The Physician's Career,* the most significant publication covering this broad subject since Joseph Garland, MD, Boston, introduced *The Physician and His Practice* in 1954, Henry F. Howe, MD, Director of the Department of Occupational Health, served as coordinating editor.

Prepared in narrative outline form, *The Physician's Career* is comprised of 15 chapters, divided into two parts—The Practice of Medicine and The Physician in the Total Community.

The handbook focuses upon the sharp transition which has occurred since two generations ago when the unaided physician was almost the only health resource in the community.



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No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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TION FOR PHYSICIANS

It calls attention to the fact that the short-term general hospital, once a place of last refuge for the terminally ill, has emerged into a highly organized, complex institution serving as a center of medical practice and providing the supporting services demanded by modern medical care.

A major change, the book points out, is the rapid evolution of group practice. Since 1948, when 3,493 physicians practiced in 368 groups, the number in group practice had more than septupled to approximately 26,000 by 1965 and is continuing to accelerate, according to preliminary information gathered in a detailed survey now being conducted by the AMA.

Chapter topics of Part One are Patterns of Medical Practice, Licensure and Accreditations, Organizations of the Health Professions, Medical Ethics, Medical Staff Organizations and Responsibilities, Teaching and Research, Business Aspects of Medical Practice and Medicolegal Obligations and Relations.

Chapter topics of Part Two are Community Health Services, Voluntary Health Agencies, Governmental Health Programs, The Modern Public Health Movement, Voluntary Health Insurance and Prepayment Plans, Medical Cultism and Quackery, and Personal, Family and Civic Responsibilities.

The AMA is encouraging state and county medical societies to utilize *The Physician's Career* as a springboard of ideas for orientation seminars for newly installed members. Copies are being provided free to members of this year's senior medical school classes. Review copies are being sent to all state and county medical societies and medical schools.

Single copies are available at 75 cents from the AMA Order Department; 90 cents in all countries except the U. S., its possessions, Canada and Mexico. A reduced price of 45 cents a copy has been set for medical students, interns and residents.

SKIN PROBLEMS

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Dry Eczema	Acne
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EXECUTIVE SECRETARY'S NEWSLETTER

January, 1968

ANNUAL MEETING RESOLUTIONS

Resolutions to be considered by the Faculty's House of Delegates at its Annual Meeting, April 17 - 19, 1968, must be received in the Faculty office NO LATER THAN Wednesday, February 21, 1968.

To date, the only resolution to be considered is as follows:

Resolution 1A/68 - Condemning Attempts by Insurance Carriers to Determine Qualifications of Physicians; and Requesting that such Carriers amend their Regulations to Prevent This.

This resolution is identical to one considered at the 1967 annual meeting, and rejected. It is being reintroduced by the Prince George's County Medical Society.

REFERENCE COMMITTEE HEARING

The Reference Committee meeting to hear comments from all interested parties to resolutions for consideration of the Faculty's House of Delegates has been scheduled for:

WEDNESDAY, MARCH 13, at 8:00 P.M.

Copies of resolutions may be obtained from the Faculty office.

1968 DUES BILLS

Dues bills for 1968 dues have been mailed to all members. Physicians are again reminded that payment of dues must be made BEFORE JANUARY 31, in order to be eligible for Physicians' Defense.

The Council has ruled that strict interpretation of the Faculty's Bylaws will preclude authorization of this benefit of membership for those members who have not complied with this requirement.

CHARTER TRIP TO LONDON

Some seats are still available on the Faculty's Jet Charter trip from Friendship airport to London's Heathrow airport. Departure is set for February 4 and return on February 10.

The all-inclusive tour, including round trip jet air fare, hotel accommodations, land arrangements and meals, is $289.00. Reservations may be made through Travel Guide Agency, Mrs. Beverly Wolins, 727-0682.

NEWS NOTES

Mikio Kato, M.D., LaVale, has been certified as a Diplomate of the American Board of Obstetrics and Gynecology.

Gilbert Barkin, M.D., Silver Spring, has been elected Chairman of the Section on Allergy of the Southern Medical Association.

Gerald A. Galvin, M.D., Baltimore, has been selected to fill the vacancy on the Board of Medical Examiners created by the death of Frank K. Morris, M.D.

New Officers of the Board are: Vernon H. Norwood, M.D., President; Karl F. Mech, M.D., Vice-President; and Walter C. Merkel, M.D., Secretary-Treasurer.

Thomas H. Powell, M.D., and Michael B. Flynn, M.D., both from Baltimore, are presently serving as Volunteer Physicians in Viet Nam, through the American Medical Association's program.

George W. Borkovic, M.D., has been elected President of the medical staff at Franklin Square Hospital. Other officers are Jesse N. Borden, M.D., Vice-President; and Nathan E. Chiodi, M.D., Secretary-Treasurer.

Winthrop M. Phelps, M.D., of Baltimore, was honored recently at a testimonial dinner in recognition of his many contributions in the field of cerebral palsy. A plaque was presented to Dr. Phelps on behalf of the American Medical Association by Houston S. Everett, M.D., Faculty Vice-President.

MEDICAL SCHOLARSHIPS

The ten State Senatorial scholarships for 1967 have been awarded to Maryland residents for their attendance at the University of Maryland Medical School. The scholarships were created by the 1965 Maryland State Legislature.

John Sargeant

Executive Secretary

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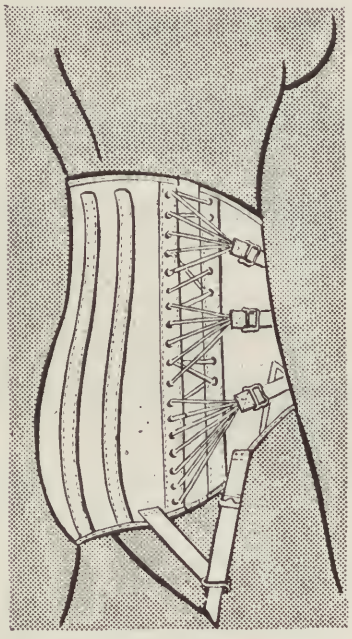
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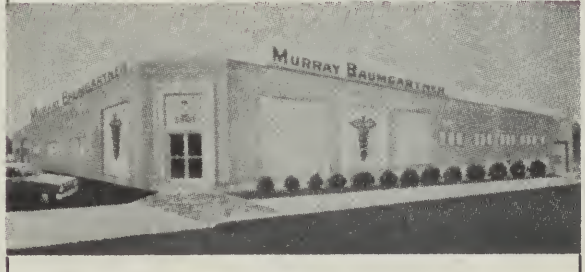


MODEL 42—Custom type garment tailored for corrective support of the sacral ond lumbar areas.

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Members of the Baltimore Association of Medical Assistants planned a project to send Christmas boxes to soldiers stationed in Viet Nam. It was decided that many of the men stationed in the war zone had families to remember them during the holidays and therefore the aim would be to reach men without families.



BAMA Christmas Project committee members (l. to r.) Mrs. Barbara Daniel, chairman; Miss Laura Baer, Mrs. Arlene Whalen and association president, Mrs. Nell Chaney, busily stuff stockings.

CHRISTMAS REMEMBRANCES TO VIET NAM

Chaplain Major Ray E. Miller, of the U. S. Army, on duty in the war zone, readily agreed to distribute these packages so they would not fall into the hands of the black marketeers or the Viet Cong and also so they would reach men that he personally knew would greatly appreciate them.

The Wicomico and Allegany Associations of Medical Assistants were invited to join in the project. A total of nine cartons comprising the donations of Baltimore City and Wicomico Associations were mailed to Chaplain Miller. Each box weighed in the vicinity of 30 pounds. Donations from the Allegany Association were mailed direct.

This was a most rewarding enterprise. The majority of the contributions came from neighborhood druggists, bakeries, pharmaceutical houses and some private contributions of money by members and doctors. A most touching contribution came from the members of the Housekeeping Department of Church Home and Hospital. At the suggestion of the Executive Housekeeper, Mr. William Milliken, whose son is now in Viet Nam, the department made this their Christmas project. These good people contributed the thirty-five dollars necessary to mail the packages overseas. Without them, the whole project would have foundered.

The packages contained such articles as razors, razor blades, candies, pens, pencils, cards, writing paper, soap, toothpaste, toothbrushes, nail clippers, small games, books, shaving supplies, deodorants, talcum, powdered hot chocolate and fruit drinks, fruitcakes, cigarette lighters, cigars, tobacco, and other such items. As originally planned, we were to try to send large packages to only three soldiers to be chosen by Chaplain Miller. Then one smaller box was sent as a small thank-you gift to the Chaplain for his help. After these boxes were prepared, there was a great supply left and so 25 giant felt Christmas stockings were purchased and packed with smaller quantities of each of the above articles. Then two cartons of books were sent and finally, one large carton of 150 small fruitcakes donated by a bakery in Baltimore, were sent for distribution as the Chaplain saw fit.

A letter was received on November 27th by our President, Mrs. Nell Chaney, which read:

> "The package marked for my personal use was received on November 19th. Thank you very much. I shall put the package away until Christmas. I shall write and let you know as the packages are received.
>
> "*You* may consider your remembrances as small, but the joy brought to the soldiers will be great. If we were to stop and think, it is the small things in life that make living so meaningful.
>
> Yours in His service,
> Chaplain Miller"

THE HIDDEN VALUE OF ADS

Recently two of our sister journals carried editorials dealing with the hidden value of drug advertising. These journals pointed out that the physician too frequently misunderstands the role that journal advertising plays.

He believes, too frequently, that the only role is a financial one for the journal he reads. He has forgotten, if he ever thought about it, that these ads carry a great deal of knowledge and information on drugs presented in a desirable and attractive manner, all available for easy reading.

All advertisements carried in medical journals are carefully screened first by the advertising departments of the drug houses and their agencies. A great amount of detail, planning, research and expertise go into the copy to ensure it is effective, ethical and legal. This requires an intimate knowledge of the product, the needs of the physician and patient, and the requirements of governmental agencies.

Perhaps he has forgotten as well that these ads are a vital source of information regarding new products and products tested by time.

Perhaps he has forgotten that these ads, in addition to providing information in themselves, provide the vehicle for the scientific material carried in papers presented at medical meetings—another important source of new information to physicians.

Rather than being critical of the advertising space purchased by drug manufacturers, the physician should be glad that they are anxious and willing to help him in the highest ethical manner.

WALLACE E. HERRELL, MD
Editor-in-Chief,
Internal Medicine



Togetherness....

...can be rough when epidemics of nausea and vomiting strike a family. Emetrol offers prompt, safe relief. It is free from toxicity[1] or side effects[2,3] and will not mask symptoms of serious organic disorders.

1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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The brunt of senility falls on the family as much as the patient. But usually within one or two days, 'Thorazine' can control senile anxiety and fear . . . dispel the confusion shown by nighttime wandering and chattering . . . restore appetite and interest in personal grooming. Treat the senile patient with 'Thorazine'—the whole family can benefit.

Before prescribing, see complete information, including adverse effects reported with phenothiazines and symptoms and treatment of overdosage, in SK&F literature or *PDR*. The following is a brief precautionary statement.

Contraindications: Comatose states or the presence of large amounts of C.N.S. depressants.

Precautions: Potentiation of C.N.S. depressants may occur (reduce dosage of such agents when used concomitantly). Use with caution in patients with chronic respiratory disorders. Antiemetic effect may mask overdosage of toxic drugs or obscure other conditions. Administer in pregnancy only when necessary. Because of possible drowsiness use cautiously and warn patients who operate vehicles or machinery.

Adverse Reactions: Drowsiness; dry mouth; nasal congestion; constipation; amenorrhea; miosis; mild fever; weight gain; hypotensive effects, sometimes severe with I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosages (in rare instances, may persist); lactation and moderate breast engorgement (in females on high dosages); and less frequently, cholestatic jaundice (use cautiously in patients with liver disease). Adverse reactions occurring rarely, include: mydriasis; agranulocytosis; skin pigmentation; epithelial keratopathy; lenticular and corneal deposits (after prolonged substantial doses).

Available: Tablets, 10 mg., 25 mg., 50 mg., 100 mg. and 200 mg.; Spansule® capsules, 30 mg., 75 mg., 150 mg., 200 mg. and 300 mg.; Injection, 25 mg./cc.; Syrup, 10 mg./5 cc.; Suppositories, 25 mg. and 100 mg.

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Book Reviews

THE OFFICE ASSISTANT IN MEDICAL PRACTICE, by Portia M. Frederick and Mary E. Kinn, CPS, W. B. Saunders Company, Philadelphia, Pa.

This is the third edition of a volume first published in 1956.

The girl who works in a medical office often must serve in many capacities. She may be a receptionist, secretary, bookkeeper and technician as well as medical assistant. Because of this, she must have a wide variety of skills and a thorough grasp of a great deal of information. She must be trained to handle each aspect of her work dependably and proficiently.

This book is designed essentially as a teaching aid in training programs for medical assistants. However, it can also serve as a handy reference book for many of the aides who have never had any formal training and have learned the tools of their trade, "on the job."

The major objectives of the book are summed up in the first paragraph of the objectives of the American Association of Medical Assistants: "To inspire its members to render honest, loyal and more efficient service to the profession and to the public which they serve."

It is a worthwhile book to have in every doctor's office.

LABORATORY MEDICINE—HEMATOLOGY, John B. Miale, MD; The C. V. Mosby Company, St. Louis, Mo.

This third edition brings up-to-date the many laboratory procedures that have been improved upon since the last publication of this book. This edition contains roughly twice the illustrations as the last; the methodology section has been revised and expanded and historical introductions have been added to various chapters. It is a worthwhile text for many physicians' offices.

CARDIOVASCULAR PHYSIOLOGY, Robert M. Berne, MD, and Matthew N. Levy, MD; The C. V. Mosby Company, St. Louis, Mo.

This book, designed for medical and graduate students, has a fundamental purpose in mind—an attempt to emphasize general concepts and to ignore isolated facts, except where they are deemed to be essential.

Simplified models have been used throughout the book, therefore, the reader must constantly remind himself of the assumption inherent in a given model and must decide whether a more detailed model is necessary at times in order to understand the specific problem with which he happens to be concerned.

The book is an excellent one for any physician to add to his library.

ATLAS OF STRABISMUS, Gunter K. von Noorden, MD, and A. Edward Maumenee, MD; The C. V. Mosby Company, St. Louis, Mo.

The diagnosis of strabismus, including its sensory adaptations and motor characteristics, depends on thorough examination and correct interpretation of a great number of subjective and objective tests. In recent years our diagnostic resources have become enlarged and refined by new procedures, and new information on the nature of sensory adaptations in strabismus has necessitated a different interpretation of some of the older tests.

This atlas does not attempt to fill the need for a comprehensive textbook on strabismus; rather it illustrates and provides basic information for the examination and diagnosis of strabismic patients in light of present knowledge.



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Dosage: Adults—1 tablet, swallowed whole to preserve timed-release feature, in morning, midafternoon and at bedtime. Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

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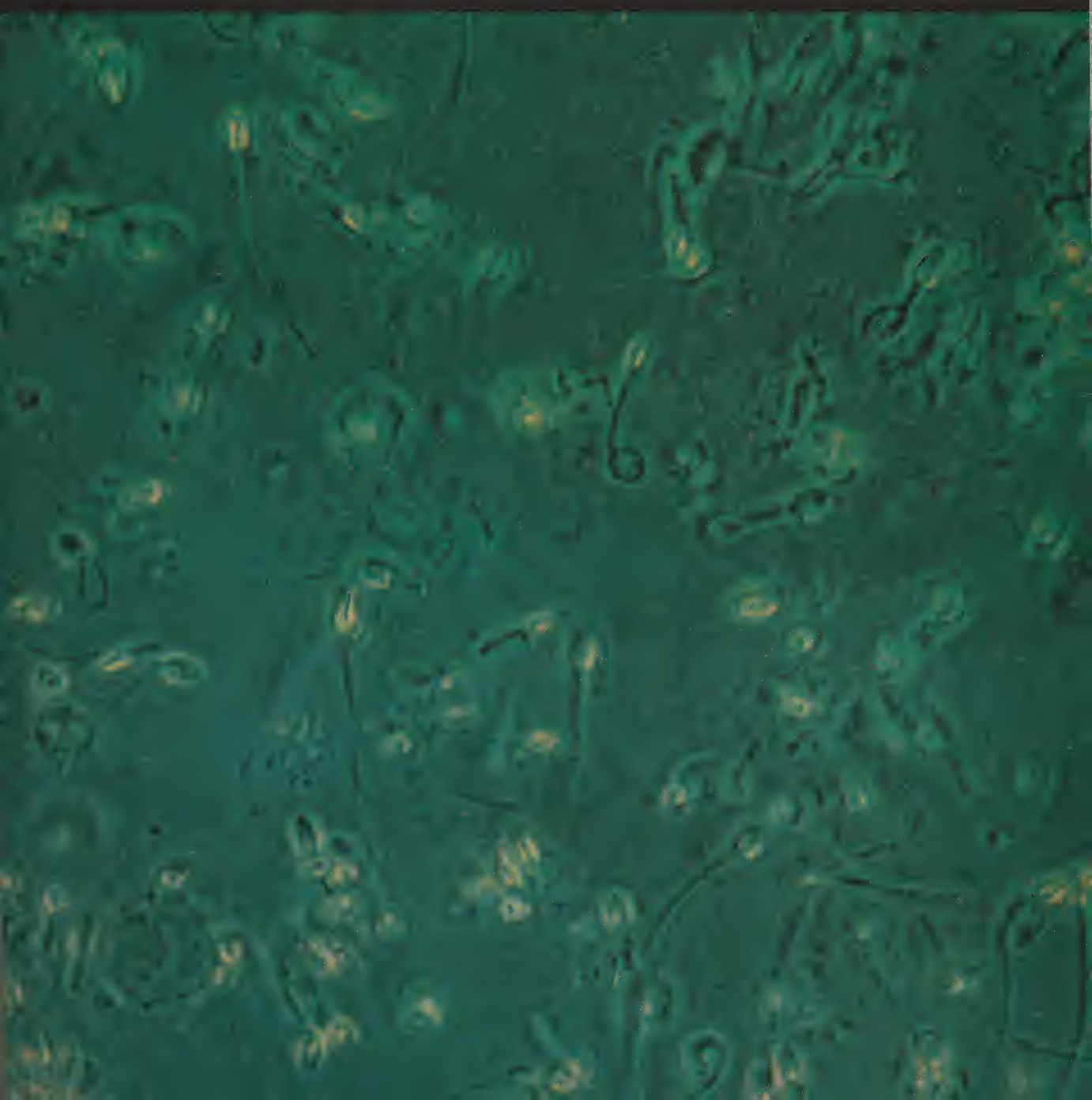
Indications: Hypothyroid conditions. **Contraindications:** Thyrotoxicosis, acute myocardial infarctions unless associated with hypothyroidism. In hypothyroidism with hypoadrenalism coadministration of corticoids with LETTER® is recommended. **Precautions and Side Effects:** Excessive dosage may result in diarrhea, cramps, palpitation, nervousness, rapid pulse, sweating. If symptoms appear, discontinue medication for several days, then reinstitute at a lower level. Since myxedema patients with heart disease may suffer seriously from abrupt increases in dosage, caution should be exercised in adjusting dosage. **Dosage:** Generally, the initial adult dosage is 0.1 mg. daily. This may be increased in small increments every one to three weeks until proper metabolic balance is achieved. **Available:** Bottles of 100 tablets, in six potencies: 0.025 mg. (violet), 0.05 mg. (peach), 0.1 mg. (pink), 0.2 mg. (green), 0.3 mg. (yellow), and 0.5 mg. (white).

ARMOUR PHARMACEUTICAL COMPANY • CHICAGO, ILLINOIS

When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. c mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Prescribing Information

Contraindications: Patients with any symptoms or history of thrombophlebitis, pulmonary embolism, liver dysfunction or disease, carcinoma of breast or genital organs, or undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. The safety of Norinyl-1 in pregnancy has not been demonstrated. If a patient misses two consecutive periods, pregnancy should be ruled out before continuing the medication. If she has not adhered to the prescribed schedule, pregnancy should be considered at the first missed period. Active ingredients of oral contraceptives have been detected in the milk of mothers who received these drugs; the significance to infants has not been determined.

Precautions: Pretreatment physical should include examination of the breasts and pelvic organs, as well as a Papanicolaou smear. If endocrine or liver function tests are abnormal during therapy, repeat tests are recommended after the drug has been withdrawn for two months. Following administration of drug, preexisting uterine fibromyomata may increase in size. Careful observation and caution are required for patients with symptoms or history of epilepsy, migraine, asthma, cardiac or renal dysfunction, cerebrovascular accident, psychic depression, and diabetes. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Possible long-term effects of the drug on pituitary, ovarian, adrenal, hepatic or uterine function must await further studies. The physician should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism. The drug should be used judiciously in those young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask symptoms of the climacteric. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation posttreatment, premenstruallike syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, and itching. The following occurrences have been observed in users of oral contraceptives (a cause and effect relationship has neither been established nor disproved): thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory tests may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from

SYNTEX

LABORATORIES INC., PALO ALTO, CALIF.

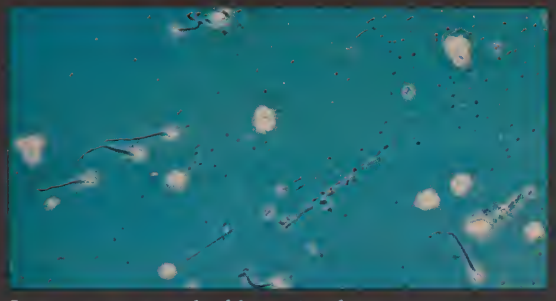
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

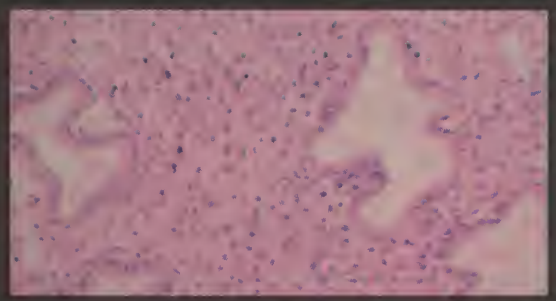
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.

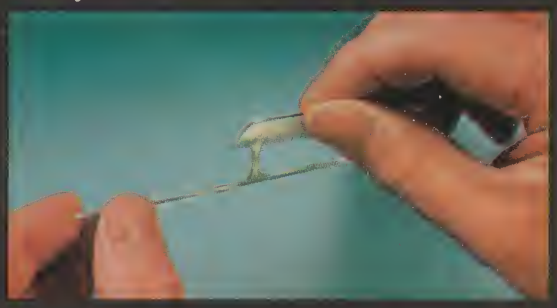


Spermatozoa appear healthy, active, freemoving.

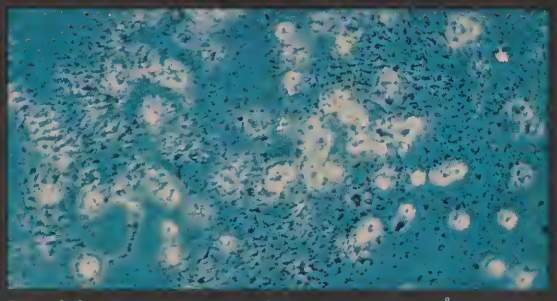


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

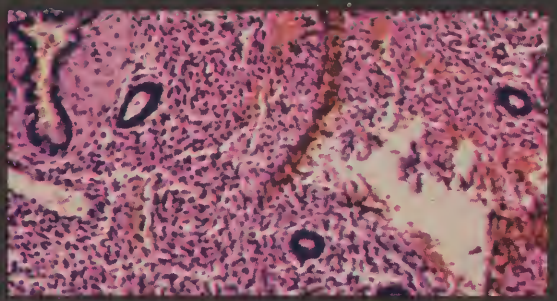
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

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Synalar®
fluocinolone acetonide





Turn page for contraindications, precautions and side effects

For everyday topical steroid therapy

Synalar® 0.01%

fluocinolone acetonide provides economy in two practical dosage forms

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Product Information

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. *Precautions:* Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. *Side Effects:* Side effects are uncommon with topical corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. In such cases the agent should be discontinued and appropriate measures taken. *Availability:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Solution 0.01%—20 and 60 cc. plastic squeeze bottles. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream—5, 15 and 60 Gm. tubes.

Fluocinolone acetonide—an original steroid from

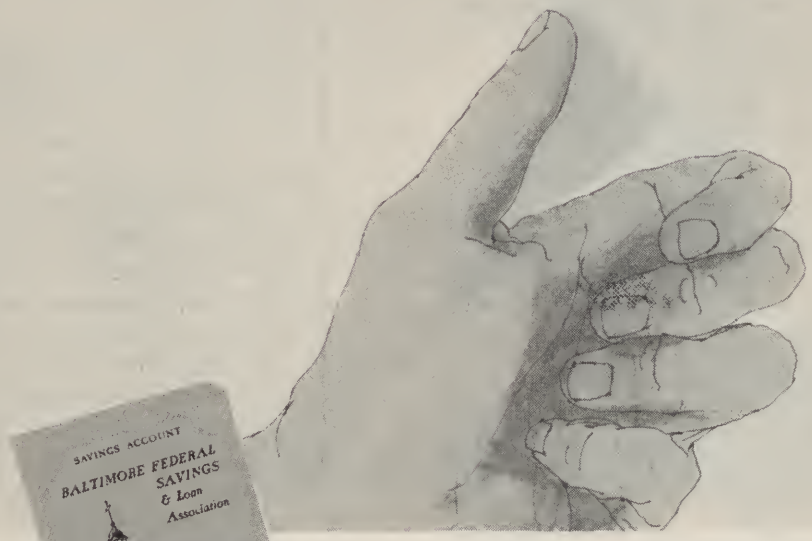
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HUMAN REPRODUCTION

Indications began to appear early last year that a "second generation" of contraceptive drugs, emphasizing long-term antifertility, are on the horizon.

Significant changes in state laws concerning therapeutic abortion also were seen during the year, and these were accompanied by indications of liberalizing attitudes toward pregnancy termination for medical reasons.

The American Medical Association House of Delegates adopted a major revision of policy on therapeutic abortion, but made it clear that the AMA still opposes induced abortion, except in certain circumstances. Prepared by the AMA Committee on Human Reproduction and approved by the Board of Trustees, the policy statement is a guide for local and state medical societies in states contemplating legislative reform.

". . . Recognizing that there are many physicians who, on moral or religious grounds, oppose therapeutic abortion under any circumstances," the new policy statement says, "the American Medical Association is opposed to induced abortion except when there is documented medical evidence that":

1. continuance of the pregnancy may threaten the health or life of the mother, or
2. the infant may be born with an incapacitating physical deformity or mental deficiency, or
3. continuance of a pregnancy, resulting from legally established statutory or forcible rape or incest may constitute a threat to the mental or physical health of the patient.

Two other physicians of recognized professional competence must examine the patient and con-

cur in writing with the recommendation for therapeutic abortion, and the gynecologic procedure must be performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals.

Two states, Colorado and North Carolina, enacted legislation similar to the AMA policy statement, while California incorporated in its laws a more liberal approach to abortion but did not include provisions authorizing abortion in case of suspected physical or mental damage to the unborn child.

Research on long-term contraceptive drugs was described at a meeting of Planned Parenthood Physicians in Atlanta, Ga. As reported in the Medical News section of the *Journal of the American Medical Association,* research centers upon: 1. implantable, sustained release preparations, and 2. two injectable contraceptive drugs that have proven safe and acceptable in clinical trials ranging up to three years in duration. Investigators indicated that testing of both types of drugs was continuing.

A scientific report of the World Health Organization urged intensified worldwide research to devise a test for predicting ovulation some days in advance. Lack of a simple, inexpensive—and above all, accurate—test for predicting ovulation is the major barrier to wider use of the "rhythm method," WHO said. The "rhythm method" of sexual continence during fertile periods of a woman's cycle is the only means of conception control sanctioned by the Roman Catholic Church and thus the only means that is fully acceptable to millions of couples throughout the world. The basic difficulty with current tests to identify fertile periods in the woman is that they are retrospective—that is, ovulation already has occurred when positive physiological signs appear.

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THE MONTH IN WASHINGTON

The National Advisory Commission on Health Manpower reported that the nation's health care system must be improved to assure that quality health care is available to all Americans at a reasonable cost.

The 15-member Commission, in its report to President Johnson, urged a substantial expansion in the capacity of existing medical schools and continued development of new schools. At the same time, the advisory group said "although the need for more physicians is urgent, the costs and dangers of a crash effort to increase production appear to outweigh the benefits."

The Commission, headed by J. Irwin Miller, chairman of the Cummins Engine Co., Columbus, Ind., was established in May, 1966, by President Johnson to recommend bold, imaginative ways to meet health manpower needs. Five physicians signed the report, including Dwight Wilbur, MD, President-Elect of the American Medical Association.

The Commission members agreed that tackling the problem of manpower, alone, would not cure present ills.

". . . If additional personnel are employed in the present manner and within the present patterns

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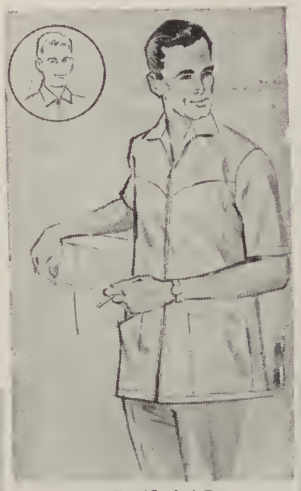
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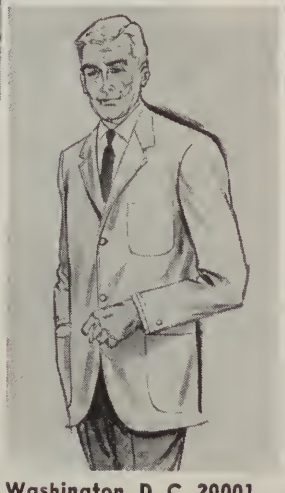
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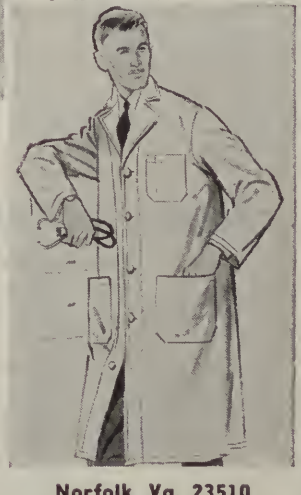
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and systems of care, they will not avert, or even perhaps alleviate, the crisis," the Commisssion said.

"Unless we improve the system through which health care is provided, care will continue to become less satisfactory, even though there are massive increases in costs and in numbers of health personnel."

The Commission's recommendations were accompanied by an assertion that government alone is not big enough to solve the problems of health care for the American people.

The **American Medical Association's** House of Delegates at its recent meeting in Houston, Texas, approved a report of the Board of Trustees on the Commission's report. The Board stated:

"The 'Report of the National Advisory Commission on Health Manpower' reflects much of the serious attention given to the evolving needs of health care long recognized, studied and implemented by the American Medical Association and other professional groups in the health fields.

"The House of Delegates and the Board of Trustees of the AMA have not had time to study the Report carefully. . . . However, it appears to recognize the needs arising from the rapid growth of the public's desire for health care. This attitude is the result of increasing awareness of the great advances in medical science and techniques, and of the prolongation of life for millions into middle and advanced ages. . . .

"The Report will receive the intensive study of the various expert groups within AMA and reports on their recommendations will be issued as soon as they can be developed properly. There appear to be some areas in which modifications will be necessary to assure attaining the objectives sought for advancement of health care for all citizens."

The Commission's proposals included:

1. Federal funds in support of capital or operating costs of education should be provided to a medical school in such a way that they create economic incentives for the school to expand enrollment while improving its quality.

2. The federal government should make available to any medical student loans to cover the full costs of tuition and living expenses during formal professional education. The student should be able to choose between repaying the loan from earnings over a period of years or giving two years of his time to approved national service apart from Selective Service obligations.

In discussing these two recommendations, Dr. Wilbur said, "I believe that principle is not sound and that the recommendations are impractical, unnecessary, will not serve the purposes intended, and will be largely unacceptable to most students."

3. The federal government should give high priority to the support under university direction of experimental programs which train and utilize new categories of health professionals.

4. At a minimum, foreign-trained physicians who will have responsibility for patient care should pass tests equivalent to those for graduates of U. S. medical schools.

5. The Selective Service Act should be amended to provide for the automatic transfer of the records of every draft-eligible health professional, upon his graduation from professional school, from the local board of his original registration to the local board in whose jurisdiction he works and for subsequent transfer with each change in the location of his work.

6. The Selective Service Act should be amended to provide equal draft-liability for U.S. and foreign medical graduates.

7. Service with the U.S. Public Health Service should be phased out as a substitute for the military obligation of health professionals.

8. The Department of Defense should be instructed to encourage the greater use of the Military Medicare Amendments of 1965 and should study the feasibility of utilizing voluntarily obtained health professionals in military facilities located in the United States.

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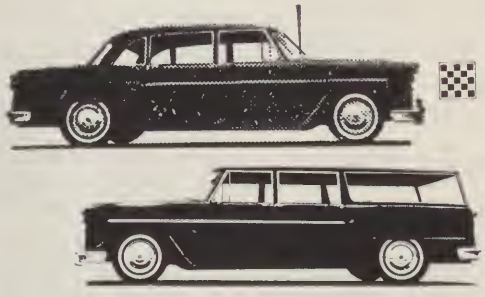
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9. Nursing should be made a more attractive profession by such measures as appropriate utilization of nursing skills, increased levels of professional responsibilities, improved salaries, more flexible hours for married women, and better retirement provisions.

10. Programs for health care of the disadvantaged should be given highest priority and made available wherever needed.

11. Professional societies, universities, and state governments should undertake, with federal support, studies on the development of guidelines for state licensure codes for health personnel.

12. Professional societies and state governments should explore the possibility of periodic re-licensing of physicians and other health professionals.

13. Professional societies, health insurance organizations, and government should extend the development and effective use of a variety of peer review procedures in maintaining high quality health and medical care.

* * * * *

President Johnson signed a $281 million mental retardation bill with a statement that the nation still is not doing enough to solve the problem.

He said that in dealing with the problem of mental retardation it was clearly the obligation of the nation to act.

"We are not doing enough, we must do more, we are going to do more," Johnson said.

The bill strengthens federal aid for the construction of new facilities for the mentally retarded.

He also signed a three-year, $589 million extensions of federal aid for state public health programs.

It provides for federal licensing of clinical laboratories operating in interstate commerce unless they are run by pathologists, in which case the facilities would have to meet standards set by the American College of Pathologists or the American Hospital Association. Individual physicians operating labs for their own patients would not be affected by the new law.

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NEW PSYCHIATRIC COUNCILOR

At its recent meeting in Atlantic City, Donato Joseph Alamprese, MD was elected a Councilor by the American Society of Medical Psychiatry. Doctor Alamprese is on the active staff of two local hospitals and has been the Director of the Outpatient Services at one of them. He is a member of many local, national, and international medical organizations. He is a Founding Member of the Guild of Catholic Psychiatrists and of the American Society of Medical Psychiatry, and a Charter Member of the Eastern Psychiatric Ass'n. He was formerly vice-president of the Blair County (Penna) Medical Society. Dr. Alamprese is a graduate of Villanova University and Temple University School of Medicine.



Donato Joseph Alamprese, MD

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Lomotil helps get children with diarrhea off toast and tea and back to normal diets and normal activity with gratifying dispatch. ▪ Lomotil lowers intestinal motility and permits absorption of excess fluid. This usually controls diarrhea promptly. ▪ Moreover, lowered intestinal motility achieved with Lomotil often relieves the abdominal cramps and discomfort so distressing to children.

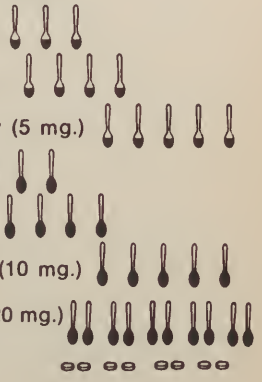
Precautions: Lomotil is a Federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is recommended. Lomotil should be used with caution in patients with impaired liver function or those taking addicting drugs or barbiturates.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of the extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

Children: Total Daily Dosage

3-6 mo. . .½ tsp.* t.i.d. (3 mg.)
6-12 mo. .½ tsp. q.i.d. (4 mg.)
1-2 yr. . . .½ tsp. 5 times daily (5 mg.)
2-5 yr. . . .1 tsp. t.i.d. (6 mg.)
5-8 yr. . . .1 tsp. q.i.d. (8 mg.)
8-12 yr. . .1 tsp. 5 times daily (10 mg.)
Adults: . .2 tsp. 5 times daily (20 mg.)
or 2 tablets q.i.d.



*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

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He's on the wagon...an

How well does Vistaril relieve the symptoms that plague an alcoholic during the recovery period? Doctors Knott and Beard of the Alcoholic Rehabilitation Unit, Tennessee Psychiatric Hospital and Institute, recently conducted a double-blind study comparing Vistaril and another well-stablished antianxiety agent with placebo in 60 hronic alcoholic patients.[1]

The investigators conclude: "It was the opinion f the staff that hydroxyzine was generally more ffective than chlordiazepoxide, for the follow-ng reasons: hydroxyzine was equally if not more ffective in reducing anxiety and tension and it roduced less daytime sedation...."[1] (See results n succeeding pages.)

ere is new evidence that Vistaril can ease ten-on, allay anxiety in chronic, hospitalized alco-olic patients. *But you might also choose Vistaril r what it doesn't do.* Although not evaluated in is study, Vistaril is reported to be non-euphor-nt, and its low toxicity makes it relatively safe. est of all, Vistaril is non-habituating. To date, ter more than ten years of clinical use, there ve been no reports of dependency in patients ceiving Vistaril.

ith Vistaril, it is as easy to op therapy as it is to start.

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the study:[1] Sixty chronic alcoholic patients were hospitalized and randomly assigned to one of three oral double-blind treatment regimens for three weeks. Twenty patients received hydroxyzine (Vistaril®), 100 mg. q.i.d.; twenty others were given chlordiazepoxide, 25 mg. q.i.d.; and the remaining twenty received placebo capsules q.i.d. The capsule code was not made known until after completion of the study and analysis of the data. Response was measured with a modification of the Brief Psychiatric Rating Scale as originally outlined by Overall and Gorham.* Subjects were rated daily by trained staff members.

SYMPTOM RATING KEY

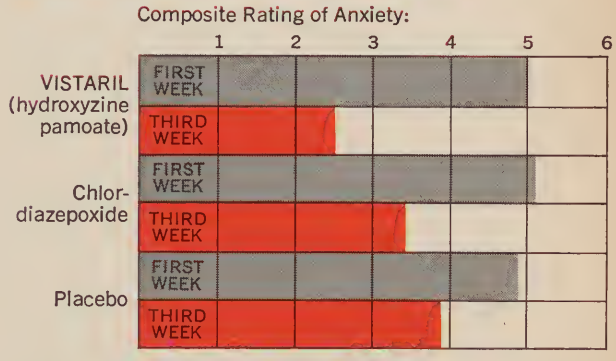
1=Not Present	4=Moderately Severe
2=Mild	5=Severe
3=Moderate	6=Extremely Severe

The figures which are given below represent the composite conclusions of the staff based on daily ratings during initial and final weeks of the study.

*Psychological Reports 10:799, 1962

the results[1] DURING FIRST WEEK DURING THIRD WEEK

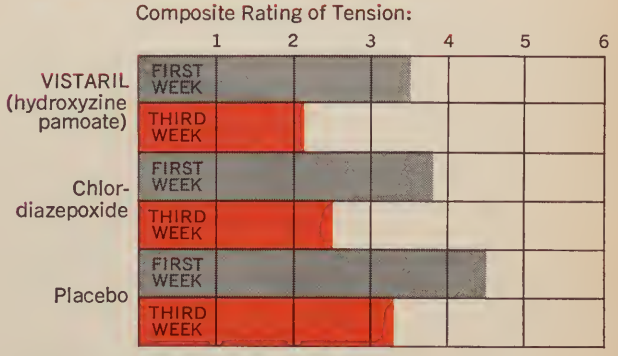
Anxiety reduced with Vistaril



OVERALL REDUCTION OF ANXIETY (%)

VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placebo
50%	33%	20%

Tension eased with Vistaril



OVERALL REDUCTION OF TENSION (%)

VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placebo
40%	34%	27%

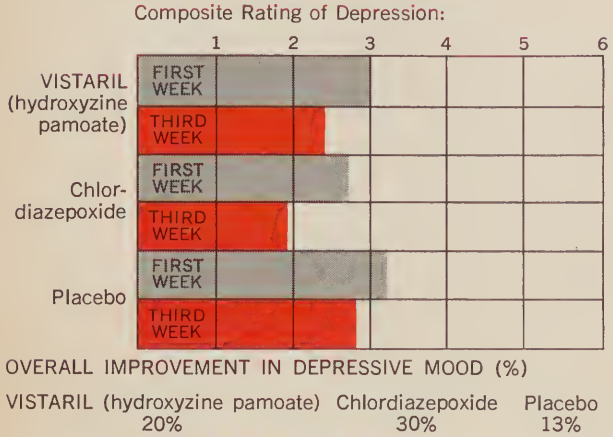
PLEASE SEE LAST PAGE FOR PRESCRIBING INFORMATION

In Alcoholism...

"Both hydroxyzine and chlordiazepoxide were generally more effective than the placebo. In some aspects, hydroxyzine was superior to chlordiazepoxide, which is currently the most frequently used psychotropic drug in the management of alcoholism."[1]

DURING FIRST WEEK DURING THIRD WEEK

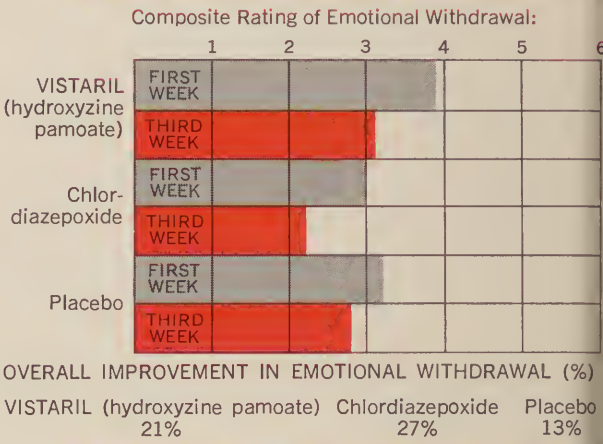
Depressive mood improved with chlordiazepoxide



OVERALL IMPROVEMENT IN DEPRESSIVE MOOD (%)

VISTARIL (hydroxyzine pamoate) 20% | Chlordiazepoxide 30% | Placebo 13%

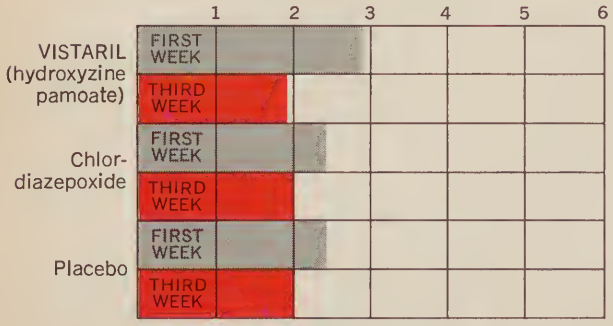
Emotional withdrawal counteracted with chlordiazepoxide



OVERALL IMPROVEMENT IN EMOTIONAL WITHDRAWAL (%)

VISTARIL (hydroxyzine pamoate) 21% | Chlordiazepoxide 27% | Placebo 13%

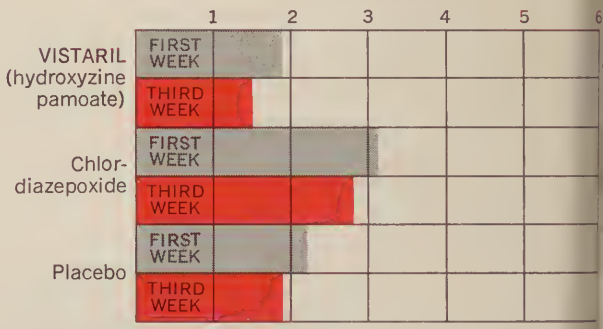
Guilt feelings allayed with Vistaril



OVERALL DECREASE IN GUILT FEELINGS (%)

VISTARIL (hydroxyzine pamoate) 34% | Chlordiazepoxide 17% | Placebo 17%

Somatic concern alleviated to minor degree in each group



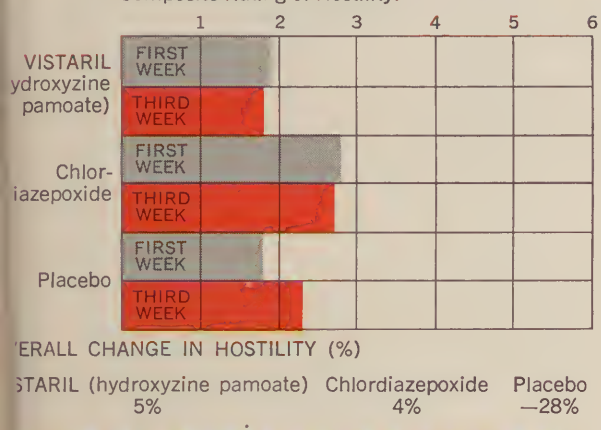
OVERALL ALLEVIATION OF SOMATIC CONCERN (%)

VISTARIL (hydroxyzine pamoate) 17% | Chlordiazepoxide 13% | Placebo 14%

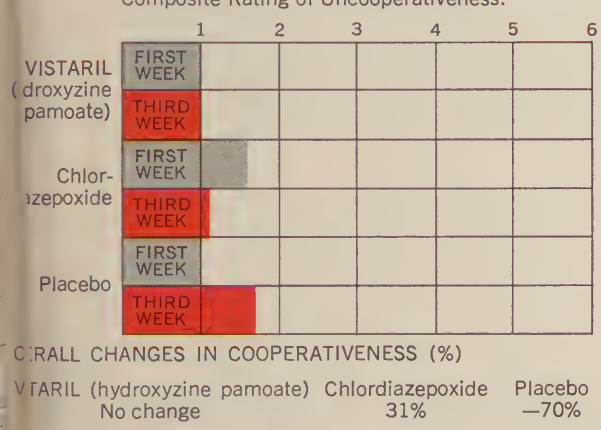
Less drowsiness with Vistaril

	Drowsiness	Dizziness	Mouth Dryness	Increased Motor Activity	Ataxia	Nausea	Comments
VISTARIL (hydroxyzine pamoate)	6 patients (mild)	3 patients (mild)	2 patients (moderate)	—	—	—	Side Effects Not Treated
Chlordiazepoxide	10 patients (severe in 6)	4 patients (mild)	—	1 patient (moderately severe in first week but gradually subsided)	—	—	Side Effects Not Treated
Placebo	2 patients (mild)	2 patients (mild)	—	—	1 patient (mild)	2 patients (mild)	Side Effects Not Treated

Increase in hostility minimized with Vistaril and chlordiazepoxide



ooperativeness not a significant problem



In Alcoholism...

Vistaril®

(HYDROXYZINE PAMOATE)

BRIEF SUMMARY

Contraindications: Hypersensitivity to hydroxyzine. The parenteral solution, for intramuscular or intravenous use, *must not* be injected subcutaneously or intra-arterially.

Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit induced fetal abnormalities in the rat at doses substantially above the human therapeutic range. Clinical data in human beings are inadequate. Until adequate data are available to establish safety in early pregnancy, hydroxyzine is contraindicated during this period.

Precautions: Hydroxyzine may potentiate the action of central nervous system depressants such as narcotics and barbiturates. In conjunctive use, dosage for these drugs should be decreased, as much as 50%. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. The usual precautions for intramuscular injection should be followed; soft-tissue reactions have rarely been reported when proper technique has been used. Hydroxyzine parenteral solution for intramuscular use should be injected well within the body of a relatively large muscle. In adults, the preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus), or the mid-lateral thigh. In children, preferably the mid-lateral muscle of the thigh. In infants and small children the upper outer quadrant of the gluteal region should only be used when necessary, as in burn patients, in order to minimize the possibility of damage to the sciatic nerve. The deltoid area should be used only if well developed, such as in certain adults and older children, and only with caution to avoid radial nerve injury. Injections should not be made in the lower and middle thirds of the upper arm. Aspiration should be done to help avoid intravascular injection. On reported intravenous injection a few instances of digital gangrene have occurred distal to the injection site, considered to be due to inadvertent intra-arterial injection or possibly periarterial extravasation. Therefore, particular caution (aspiration and site injection) should be observed to insure injection only into intact veins; avoid either intra-arterial injection or extravasation. Intravenous administration should be accomplished slowly, no faster than 25 mg. per minute, and not to exceed 100 mg. in any single dose. In order to avoid possible adverse effects it is recommended that hydroxyzine parenteral solution be diluted to at least 50 cc. with sterile normal saline and administered over a period of four minutes or more, preferably into the tubing of a running intravenous infusion.

Adverse Reactions: Drowsiness may occur; if so, it is usually transitory and may disappear in a few days of continued therapy or upon dosage reduction. Dryness of the mouth may occur with higher doses. Involuntary motor activity, including rare instances of tremor and convulsions, has been reported, usually with higher than recommended dosage.

When this product is given intravenously undiluted, minimal amounts of intravascular hemolysis occur at the site of injection. Giving the maximum recommended intravenous dose (100 mg.) to adults results in immediate transient hemolysis with the liberation of a total of 2-3 grams of hemoglobin, which, in some individuals, can cause small amounts of hemoglobinuria. This compares with the normal red cell destruction from which approximately 8 Gm. of hemoglobin are liberated every 24 hours. If the hydroxyzine is diluted with 50 cc. of normal saline and given during a period of four minutes or more, this phenomenon does not occur.

Supply: Vistaril (hydroxyzine pamoate) Capsules: Equivalent to 25 mg., 50 mg., 100 mg. hydroxyzine HCl. Vistaril (hydroxyzine pamoate) Oral Suspension: Equivalent to 25 mg. hydroxyzine HCl per 5 cc. teaspoonful. Vistaril (hydroxyzine HCl) Parenteral Solution: 25 mg./cc.—10 cc. vial and 50 mg./cc.—2 cc. and 10 cc. vial; Isoject,® 25 and 50 mg. per cc., 1 cc. per unit.

More detailed professional information available on request.

Reference: 1. Knott, D.H. and Beard, J.D.: GP 36:118, September, 1967.

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Prescribing Information: Composition: Each white, beveled, compressed toblet contoins: Quinine Sulfote 260 mg. ond Aminophylline 195 mg. **Contraindication:** QUINAMM is controindicoted in pregnoncy becouse of its quinine content. **Precautions:** Aminophylline moy produce intestinol cramps in some instonces, ond quinine moy produce symptoms of cinchonism, such os tinnitus, dizziness, ond gostrointestinol disturbance. Discontinue use if ringing in the eors, deofness, skin rosh, or visuol disturbonces occur. **Dosage:** One toblet upon retiring. Where necessory, dosage may be increosed to one toblet following the evening meol ond one toblet upon retiring. **Supplied:** Bottles of 100 ond 500 toblets. **References:** 1. Shumon, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et ol.: Angiology, 12:102, 1961. 3. Rowls, W., et ol.: Med. Times, 87:818, 1959. 6/67 Q-706A

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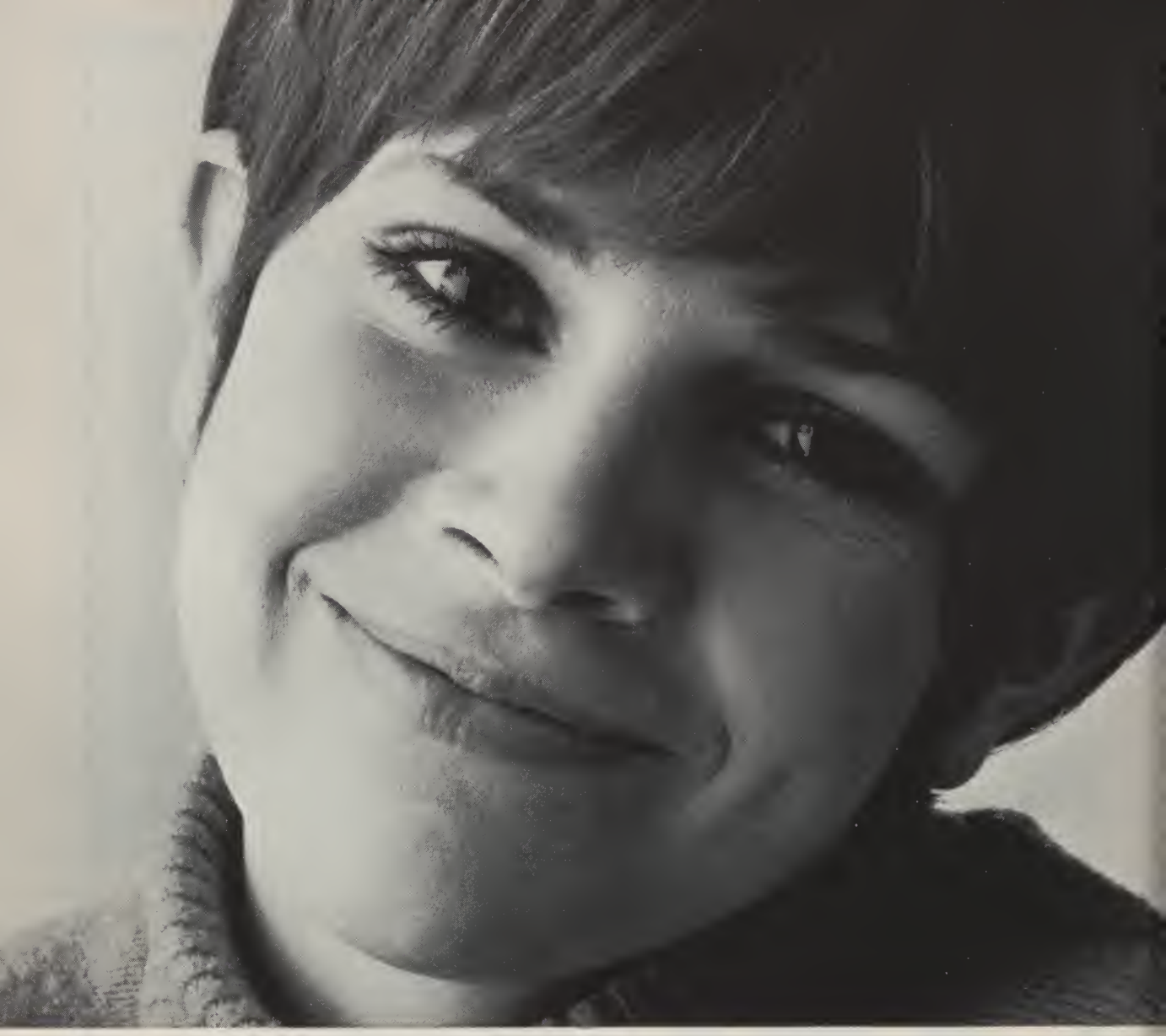


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Indications: Infections susceptible to oral penicillin G: propnylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
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Editorial

Maryland State Medical Journal
Vol. 17, No. 1
January, 1968

GUIDELINES LAID DOWN

Another milestone was recorded at the Faculty's semiannual session when the House of Delegates unanimously adopted a Physician/Pharmacist Code of Cooperation that has since been adopted by the Maryland Pharmaceutical Society.

Guidelines for physicians and attorneys had already been established by the 1964 Code of Cooperation between the Medical and Legal professions that provided a sounding board for misunderstandings and clarifications in problem areas.

While there is probably less of a gulf between the physician and the pharmacist than between the physician and the attorney, the success of the earlier code adopted by the House of Delegates provided a basis for the new code between the related professions. The main point established being the differences in the philosophy of the two professions.

In the code, physicians agree to give patients a free choice of pharmacy and in turn, pharmacists are responsible for carrying a complete line of pharmaceutical products to fill all prescriptions even though a drug may be considered somewhat esoteric and is, perhaps, rarely prescribed.

Also fully discussed and firmly established is a code concerning "kickbacks," "rebates" and "fee splitting." And although physicians and pharmacists recognize these as illegal procedures, misunderstandings have arisen in regard to the fine points of the problem.

Simultaneously with the House of Delegates meeting, the Council adopted a provision that Rx blanks should not contain imprinted codes indicating the number of refills for a prescription. This decision was reached based on the practice of the patient changing the physician's directions therefore resulting in abuse of the prescribed drug. It is hoped that this provision will lead to a reduction of any abuse that might take place.

But the main purpose in establishing the Physician/Pharmacist Code of Cooperation is to furnish firm guidelines for the newly-licensed physician and pharmacist, as well as to delineate the standards which physicians and pharmacists have practiced for years.

John Sargeant
Executive Secretary

CRYOSURGERY AND ITS APPLICATION TO EAR, NOSE AND THROAT SURGERY

CHARLES L. HILL, MD
Providence, Rhode Island

Cryosurgery is basically a therapeutic technic which relies upon tissue necrosis in response to lowering of temperature. This basically is dependent upon devascularization of tissue and permeability of cells to water. It is not really a new find—it has been used for hundreds of years. Initially, cold, in the form of ice in brine solution, was used by the ancients to slow metabolism in treatment of anything from infection to cancerous tissue and apparently this worked for awhile. We are more familiar with the dermatological use of cold, using dry ice on warts and other skin lesions.

The controlled use of cold started with Irving Cooper, MD, in New York four or five years ago when he, in conjunction with the Union Carbide Corporation, developed a machine using a circulating liquid refrigerant. This was liquid nitrogen which would produce temperatures in the area of 196° below Centigrade. The equipment was relatively accurate, and could maintain this temperature for a relatively long time—as long as the nitrogen stayed in reserve. They were able to develop an applicator which could be varied in size making the usefulness of this more widespread in the treatment of different size lesions.

The other refrigerant used was Freon. This does not get as cold and reaches about 80° below Centigrade.

The basic structure of the equipment that is used now is a tube within a tube within a tube. If you can picture the sleeve interrelationship of these conduits, the inside tube supplies the liquid to the tip which is generally a hollow applicator, varying in size and shape, depending again on the area of tissue and the particular location you want to freeze. When this liquid enters the tip, it becomes vaporized, and turns into a gas, which then is exhausted through the second tube, and is either expelled through the handle or through the back of the machine.

The third tube acts as an insulating device, and some of the equipment acts as a vacuum or is just an air-containing sleeve. On the newer equipment there is some kind of defrosting device on the tip, so you don't have to wait for the body to defrost the tissue to allow you to take away the probe from the area which you are freezing. The area exposed to the cold, the tip temperature and the time of exposure determine the amount of necrosis of the tissue with which you are concerned.

Cause of Injury and Death in Frozen Cells

The pathophysiological cause of injury in the frozen cells is basically three-fold. The first is thermal shock.

This occurs through the rapid cooling which appears to affect the permeability of the cells in both the water and the electrolytes. This is not a major factor in cell death. Dehydration and solute concentration is more prominent because of necrosis with extracellular freezing. There is an

Given before the Maryland ENT Society Nov. 8, 1966, at 8 P.M. in the Jubilee Room of the Sheraton-Belvedere Hotel, Baltimore, Md.

increase in the solute concentration. As freezing progresses, the solutes precipitate, and eventually all the water will freeze. This is called the eutectic point. It is actually the increase in solute concentration which affects the molecular structure of the enzymes and cell membranes. This is apparently where a great deal of the necrotic effect of cold lies.

The third important cause of death is injury from ice formation itself. Intracellular freezing as opposed to extracellular freezing depends upon the rapidity of cooling. The faster the cell is cooled, the larger the ice crystals formed within the cell. It is these larger ice crystals that appear to be more lethal. The amount of information that we have as to what causes the death of the cells is not very great at this time. There is a tremendous amount of basic research going on to determine just how cold the tissue should be and just how long you should freeze to actually get necrosis. In conjunction with this there is an optimum freezing necessary to obtain necrosis of different cells depending on permeability of the cell membranes, and what is extremely important now appears to be the time of thaw. Here again this is something we don't know very much about. We don't really know the basic causes of its action.

The anesthesia involved is a matter of preference. The cold itself has an effect on the nerves in that it will initially provide a burning sensation that lasts for about 30 seconds. When the burning sensation disappears you have a relative ice anesthesia.

Dr. Hill's Study of Tonsils

In an effort to find a treatment for carcinoma of the nasopharynx, Dr. Cooper's work was thought to have some application to the problem. We thought the best way to study the effects would be to study tonsils. It turned out that actually the process had more application to the tonsils than it did to carcinoma of the nasopharynx.

In starting the anesthesia with the tonsil in the patient—initially this work was done with dogs, then we had volunteers—we sprayed the throat with some topical anesthetic, and then one tonsil was infiltrated with Xylocaine (*lidocaine*) or Novocaine (*procaine*). The discomfort associated with a topically anesthetized tonsil was about as uncomfortable as the needle.

Other Uses of the Cooper Probe

The same process can be used anywhere in the body. There is some discomfort for 30 seconds after the thaw starts. This can be relatively severe, but apparently as long as the patients are warned about this, it doesn't bother them too much.

The time of application of the cold probe is something that varies with the tissue, the type of tissue, the mass of tissue to be destroyed, and the vascularization of the particular tissue. There appears to be no definite time sequence as yet. Visually you can see how long or how wide your zone of freezing is, and this helps to determine how long you can freeze the area.

Basically the method is freezing the tissue until the frost line extends to what you consider to be normal tissue—you can see this white extension going into the normal tissue. Then you can stop and thaw. There is an area of reversibility.

This is most dramatically illustrated by Dr. Cooper's use of this. He will take an individual with Parkinson's disease who has a severe tremor. (He does the procedure under local anesthesia, so he is doing a neurological examination on the patient all the time.) The patient will have a hand that is just quivering and cannot really move the fingers. He will try to get them together. He will put the probe in, start to freeze, and slowly you will see the hand start to relax, and the quivering will stop, and suddenly the patient can just take his fingers and put them together. It is an extremely dramatic thing to see. But he is doing other neurological examinations as he does this.

If he starts to get some sensory change he will stop in the knowledge that although the cold has affected these cells, when it thaws the reversibility will be present so he does not really have necrosis. He only destroys necessary tissue.

This is true no matter what you are freezing. It can be frustrating, because you think you have destroyed something but in fact when it thaws it will return to normal. Because of this it appears now that at least a two-cycle freezing time is necessary.

Most of the work that has been done has been related to just one time of freezing, whether it be 2 minutes or 5 minutes or 8 minutes or 10 minutes. The tissue has been frozen for that length of time, and then it has been allowed to thaw. You wait two or three weeks to see what happens.

Wm. George Cahan, MD, at Memorial Hospital in New York, has been using a double freezing technic right from the start. We had been a little worried about this because some of the pathological slides that we looked at showed signs there was cell change that suggested this might be a carcinogenic agent. The slide taken from tissue which had been frozen only once was all right. It didn't have the chromosomal changes.

So what we did was to take tonsils and freeze them, let them thaw over 3 or 4 minutes, refreeze them, take biopsies of the tonsil, examine them under the microscope, and also plant them in tissue culture. Our genetics chief, Paul LaMarche, MD, looked at several of these tissue cultures and then examined the cells that were growing under the microscope, made solutions from the cells which were injected back into the patient in several different sites, and then looked to see if we were getting any kind of sarcomatous growth. Fortunately there was no problem whatsoever.

We also took serum solution for antibody formation, looking a little bit further ahead, to see if we were perhaps stimulating antibody formation. This might have some application towards cancer control. There is a lot of work going on in this area.

It takes about 8 minutes to freeze a 2 cm ball of tissue, no matter what this tissue is—liver or tonsil or muscle (except bone)—at a temperature of below 80° Centigrade. It does not seem to make any difference whether it is 190° below Centigrade, it still takes about 8 minutes.

The material we used has been predominantly tonsil tissue in adults. We don't think this has an application to children, because there is a certain amount of discomfort associated with it, requiring a general anesthetic. If a child should jump and the probe is torn away from the tonsil, you will get avulsion of the tissue and bleeding, much as when one's tongue is burned on an ice tray. Once you have the child asleep, you might as well go ahead and do the tried and true procedure. This is no better, and I don't think it is really as good as the routine tonsillectomy.

Ninety patients have been done with a single cycle of freezing each tonsil for between 3 and 6 minutes, depending on the size of the tonsil. Three of these people continued to have symptoms after the freezing. They did well for a month or six weeks, but then they would start to have tonsillitis, and we would have cultured Strep infections. We surgically removed these tonsils both because we wanted to get the patient better, and we were also interested in the pathological examination of the tissue. What this tissue showed was areas of scarring and normal germinal follicles. The operation was perhaps a bit more difficult than it would otherwise have been because of the scarring, but in these patients we could have gone back and refrozen the area if we had wanted to.

An interesting factor is the amount of destruction of the tonsil tissue varied between 90% and 20%. In some of these patients, when examined three to four weeks or even a month later it would seem nothing had been done as far as destruction of tissue is concerned, and yet we have patients who three years after freezing have absolutely no symptoms. These are patients we would have expected to have three or four bacterial infections a year.

Double Freeze Technic

It has just been within the last five or six months we have been doing a double freeze technic on 20 patients. Destruction is much greater, between 70 and 90%. This basically is in using the applicator whether it is the Freon machine, or the Cooper treatment with nitrogen. Freezing time is about 5 minutes on one tonsil. You freeze the other tonsil; while you are freezing that, the first one will thaw. Then you go back to the first one and freeze that again for 4 minutes.

There is the initial burning and discomfort that has been mentioned earlier and there is a moderate amount of edema. If you look in the mouth you will see some edema of the uvula and the soft palate. This seems to bother the patient for about 12 hours. Then anywhere from 12 to 24 hours he will start to have significant sore painful throat. We have taken several patients and frozen one tonsil, then removed the other surgically under local anesthesia, and some under general anesthesia, and all of the patients have agreed the discomfort from freezing is about half that which accompanies surgical removal.

About the third day the patient will start to notice a white necrotic area starting where the probe was applied and extending over most of the tonsil tissue. Basically this is frostbite that we have created and necrosis of the tissue will start. The patients then gargle with saline and there has

never been any problem with significant chunks of tissue being aspirated or causing any particular complication. This usually progresses anywhere from 7 to 14 days. Then the fossa epithelizes over, and you may either have a typical surgical fossa or the mucosa will be intact and the patient's discomfort will clear.

Of the 120 patients that we have done specifically at the hospital, we have had two episodes of bleeding. One could be classified as hemorrhage. This was at about the 10th day. It was relatively easy to handle. The other was blood in the sputum which the patient reported when she came in for a routine visit.

At the Academy meeting in Chicago one Doctor in Ohio reported three cases of bleeding. One of these required cauterization.

We have used the freezing process in treating carcinoma. The only real cure we have was of epidermoid carcinoma on the floor of the mouth of a 90-year-old man. We froze him with local anesthesia, and he is now two years post-freeze with no evidence of recurrence. He had a tumor involving both submaxillary ducts, but no swelling of the glands. He never had any pain associated with stenosis following freezing.

Also, we have used the process in palliation. In patients with carcinoma of the larynx, where the hypopharynx is completely obstructed requiring gastrostomies or tracheotomies, we have placed the *Cooper probe* in the middle of the tissue to freeze it. Visually we got an ice ball involving the tumor, resulting in a remarkable amount of pain relief. Several of the patients opened up to the extent they could take liquid diets.

There are other areas of the country where actual cancer therapy is being attempted using cryotherapy. It is useful in certain instances, but in no way should it be construed to be something that is going to supplant surgery or X-ray or a combination of the two.

An application of this is as a hemostatic agent. One patient in particular, a dental patient, had an extraction and it turned out he had a type of clotting abnormality. He bled profusely from the tooth socket even though it had been packed and sutured, and required transfusions amounting to 32 units. We inserted the *Cooper probe* in his tooth socket and in two minutes the socket stopped bleeding permanently.

In cases of spot bleeding for epistaxis this treatment has proved successful. We have a unit in the office with different types of probes we can use. Particularly exciting is the use of the probe in spot bleeding of telangiectasis. We freeze the spot for 2 minutes, and it will stop bleeding for several months. It is not a permanent cure, but it is a lot better than anything we have been able to do before.

Along this same line I want to mention the cryosurgical equipment initially used for the treatment of gastric ulcer which C. D. Bluestone, MD, in Pittsburgh, adapted to the treatment of epistaxis. When we started we would place an ordinary child's balloon in the nose and hook it up to the gastric cooling unit and circulate alcohol in the balloon for about an hour. Dr. Bluestone has brought this timing down to about 6 minutes. This has dramatic results, patients stop bleeding almost immediately. The balloon is left in the nose and usually the catheters leading into the ballon are clamped, leaving it inflated overnight. Perhaps it it is just the pressure of the liquid-filled balloon which accounts for this method's success, however, we have used other things with nowhere near the success.

Our residents were freezing a man with hemorrhagic telangiectasis, who looked as if he had a faucet in his nose when he started to bleed. His nose was frozen six months ago and for the first time in thirty years he had gone six months with absolutely no bleeding at all. He came back in with extensive bleeding and required four or five units of blood. He was refrozen, and the bleeding stopped.

Also, cryotherapy has been effective in treatment of polyps in the nose. Hans V. von Leden, MD, in California, has reported taking the probe, inserting it in the nose with no anesthesia, freezing, and removing the polyp.

Other doctors are using it for hypophysectomy going through the septum and inserting the probe up through the spur into the hypophysis. Here again they are very aware of reversibility. If they start to observe visual symptoms, they stop. They know they are going to have reversibility.

This is not a panacea. The treatment is applicable where tissue necrosis is desired. Basically, the method has its advantages over cautery and produces the same result. The procedure is relatively painless to the patient, and much more pleasant for the physician than cautery.



Lewis H. Steiner, MD
May 4, 1827-Feb. 18, 1892

With the death of Amy L. Steiner on November 17th, 1966, the Faculty Library received the principal of a trust established by Walter Ralph Steiner, MD, at the time of his death in 1942. The trust was to be known as the Lewis Henry Steiner Fund in memory of his father, also a physician, who transferred his allegiance to library work and served as the first librarian for the Enoch Pratt Free Library.

THE STEINER INHERITANCE

The roots of the Steiner family in America stem from the earliest years of this country. Of German descent, the first immigrant was Jacob Steiner who settled in Frederick County prior to 1736. On the distaff side, the ancestry is traced through Rebecca Weltzheimer Steiner who was also a native of Frederick, Md.

Lewis Henry Steiner was born in Frederick on May 4, 1827. He attended the Frederick Academy, Marshall College in Mercersburg, Pa., graduating in 1846 with an AB degree. After graduation he began the study of medicine under the preceptorship of William Tyler, MD, of Frederick. He then attended the University of Pennsylvania Medical School where he received his MD degree in 1849. He practiced a short time in Frederick then moved to Baltimore in 1852 to begin the teaching of medicine in a private medical institute owned and operated by R. J. W. Dunbar, MD. Deciding to give up the teaching of medical science, he transferred his attentions to the teaching of natural sciences in 1855.

In 1856, Dr. Steiner became active in the reorganization of the Maryland College of Pharmacy of which he held the Chair of Chemistry until 1861. He did not neglect his early training, however, for he was an active member of the Medical and Chirurgical Faculty of Maryland from 1853 until his death, as well as being actively interested in the American Medical Association.

He was active also in other scientific groups such as the American Association for the Advancement of Science, the American Public Health Association of which he served as a vice-president; and many others. When the Civil War broke out, Dr. Steiner elected to enter the service of the U. S. Sanitary Commission and in 1861 he was appointed Inspector and in 1863 Chief Inspector with the Army of the Potomac during the campaigns of 1863 and 1864. His experiences are told in two reports issued in 1862 and 1863, and in a brief history of the Sanitary Commission published in 1866. These marked the beginning of a prolific writing career for Dr.

Steiner in all of his chosen fields on subjects of particular interest to him. After the close of the Civil War in 1865, he returned to Frederick where he served as President of the Frederick County School Board. In this capacity he became particularly interested in providing school facilities for Negro children.

On October 3, 1866, he married Miss Sarah Spencer Smyth, daughter of the Hon. R. D. Smyth, of Guilford, Conn. Of their five children, three were daughters, Gertrude, Bertha and Amy; and two were sons, Bernard, who became the second librarian at the Pratt library, and Walter Ralph, who shared his father's medical interests. From 1856 to 1861 Dr. Steiner served as assistant editor of the American Medical Monthly of New York. He contributed frequently to the Southern Quarterly and the Mercersburg Quarterly Review. He presented countless scientific papers at various learned societies. He was honored by the College of St. James in 1854 with the degree of AM (Honoris Causa); and by Yale University in 1869 with the same degree. In 1884, Delaware College conferred upon him an LLD degree and three years later, Franklin and Marshall College honored him with a LittD degree.

Dr. Steiner was selected in 1884 by the Trustees of the Enoch Pratt Free Library to serve as first librarian. He devoted his tremendous talents and energies to the establishment of the firm base upon which the Pratt stands today. During the first eight years of the library's development, he worked closely with Enoch Pratt. They were close personal friends and their two families were intimately associated.

He died in 1892 and his son, Bernard, was chosen as his successor.

Walter Ralph Steiner

Walter Ralph Steiner, familiarly known to his friends and classmates as "Bob" or "Dutch" was born on November 18, 1870, in Frederick County.

He received his early schooling at the Frederick Academy and University School of Baltimore. He graduated with a BA degree in 1892, from Yale; and received an MD degree from The Johns Hopkins School of Medicine in 1898. He was closely associated with Osler, Halsted and Kelly and worked with them until 1900 when he moved to Hartford, Conn. to enter the private practice of medicine.



Walter R. Steiner, MD
Nov. 18, 1870-Nov. 4, 1942

Because of the intense interest in the Faculty's library demonstrated by his father, who served on the Library Committee and was instrumental in organizing and maintaining interest in the early days of the medical library; and because of Sir William Osler's close connection with the Faculty and its library, Dr. Steiner was effective in building up the library of the Hartford Medical Society so that it eventually became the best medical library in any city of the nation the size of Hartford.

He did not devote his attention to collections of medical books only, however. At the time of his death in 1942 he bequeathed his rare and extraordinary collection of books on Nathan Hale to the State of Connecticut. Dr. Steiner left his collections on Hawaii, John Paul Jones, and the prison camps of the Civil War to the Library of Congress. His rare medical books were willed to the Faculty with the provision that any duplicates be turned over to the Johns Hopkins Medical Library. Dr. Steiner's own literary contributions to medical and other journals are innumerable.

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METASTASIS AND DEVELOPMENT OF MALIGNANCY IN BENIGN COLONIC POLYPS

Do benign adenomatous polyps of the colon become malignant or are malignant polyps cancer from the beginning? This is a subject that has found divergent support in the literature from equally qualified surgeons.

JOHN W. BERGHUIS, MD
Adrian, Michigan

Classification of Polyps

According to Welch[1] a good deal of confusion is due to the fact that many institutions have revised their classification of polyps. For instance, 10 to 12 years ago 8% of the colon adenomas at Massachusetts General Hospital were of the villous type. Whereas in the past few years the villous type comprised 28% of all adenomas at the same institution. Twenty or more years ago it was widely held that all adenomas would eventually degenerate into cancer, should the patient live long enough. Sunderland and Binkley[2] have done much work in the differentiation of villous adenomas and simple adenomas. This separation made it apparent that the villous adenoma accounted for much of the "cancer in polyps" that had been reported previously.

Spratt, Ackerman and Moyer[3] feel that simple adenomas very rarely, if ever, develop into cancer. They state that they have never found a case of metastatic carcinoma that originated in a carcinomatous colonic polyp in which the stalk did not contain neoplastic cells.

Knoernschild[4] studied 257 patients with asymptomatic benign polyps. Of this group 213 were followed for a period of 3 to 5 years. During that time 70% of the polyps remained the same size. However in 4%, the polyp increased significantly in size, while in 18% it had disappeared entirely. Two adenomas did change in appearance and were proved by biopsy to have developed into cancer.

Welch[1] believes that most simple adenomas remain benign during the life of the host. On the other hand, he believes carcinoma develops much more commonly in simple adenomas than in the normal mucosa of the colon and rectum. He reasons if one compares the number of mucosal cells in an adenoma with the number in a host's intestine and assumes the cancer potential per cell to be the same, then one should see many more cancers arising in the colon as compared to an adenoma. This is not the case, for many more cancers are found in adenomatous polyps, in relation to the number of cells present, than *denovo* from normal mucosa. Following is a case which lends support to the theory that benign colonic polyps do become malignant and indeed metastasize.

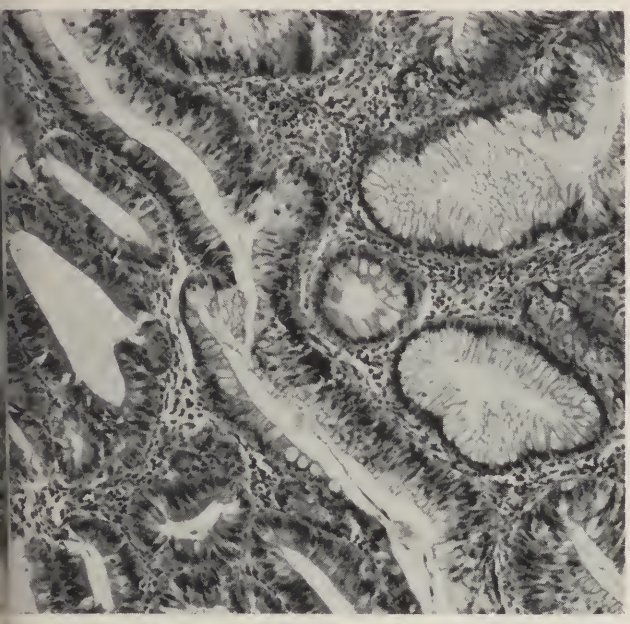
Case Summary

M. L. is a 40-year-old woman who has been in excellent health. She first noted bloody mucous in her stools in mid-December 1966. Barium enema

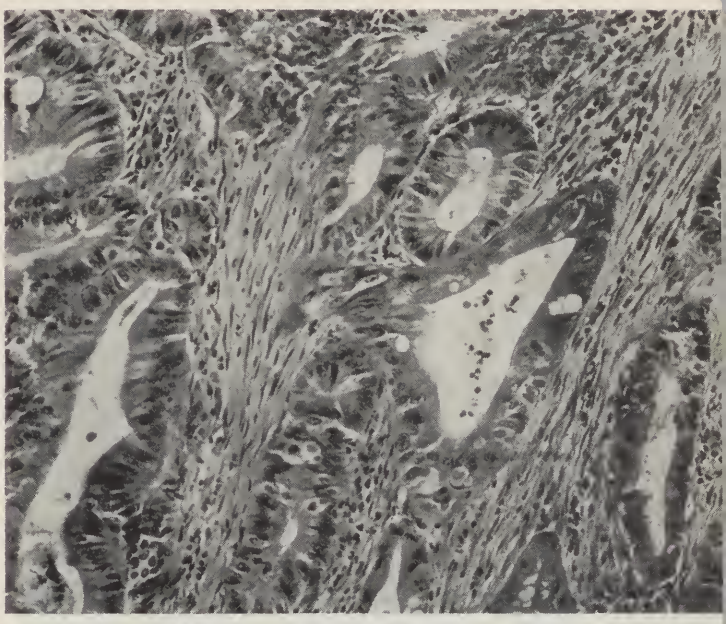
examination of the colon revealed a radiolucent defect in the sigmoid colon. Re-examination of the colon in January failed to demonstrate the filling defect.

Although the history was quite typical of a colonic polyp, with recurrent periodic passage of bloody mucous and blood-streaked stools, a repeat of the colon examination was delayed for personal reasons. Repeat examination of the colon on April 21, 1967 again demonstrated a polyp in the mid-sigmoid colon.

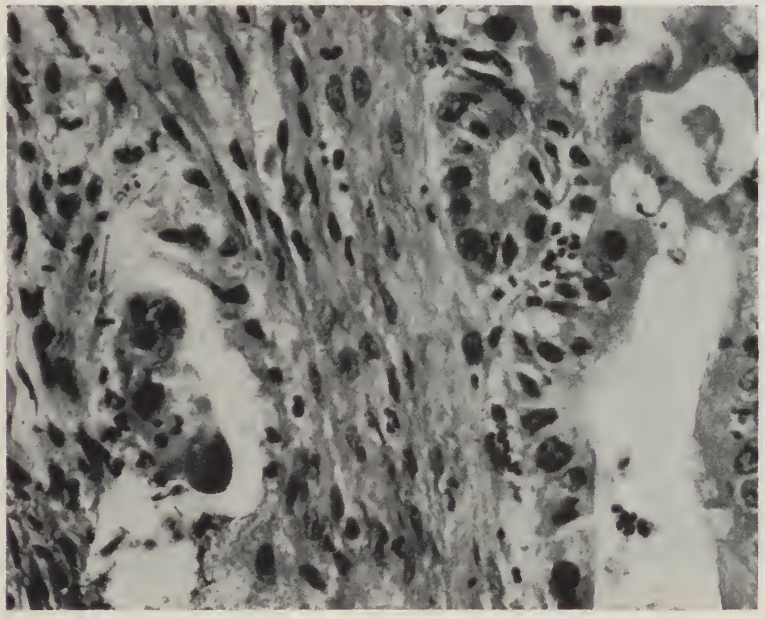
On April 27, 1967 laparotomy and sigmoid polypectomy was performed. The polyp was situated on the antimesenteric wall of the bowel, and



Benign and malignant components in the same colonic adenomatous polyp.



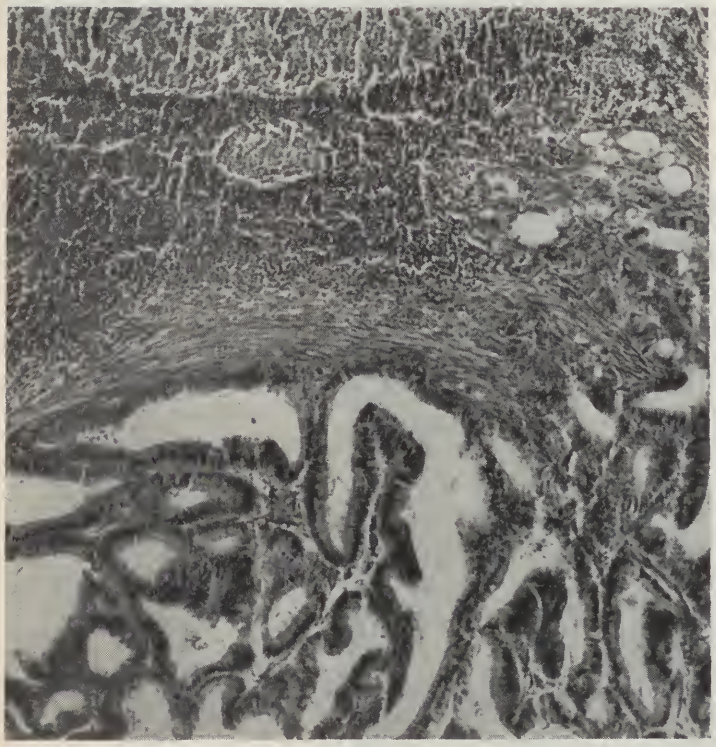
Invasive adenocarcinoma with associated fibrous reaction.



Tumor emboli in lymphatic channels.

was approximately 2 cm in diameter with a moderately broad 1.5 cm stalk. The stalk was amputated approximately 1 cm distal to the base of the polyp. Frozen section examination showed an atypical polyp with no evidence of tumor involvement at the point of amputation of the pedicle. The permanent sections, however, revealed a "primary polypoid superficially invasive well differentiated adenocarcinoma rising in an atypical adenomatous mucosal polyp of the sigmoid colon." There was no carcinoma at the point of transection of the stalk. There was, however, evidence of tumor emboli in lymphatic channels.

In view of these findings on April 29, 1967 sigmoid colectomy with a wide resection of the mesosigmoid was performed. The liver was grossly free from metastasis. There were no clinically enlarged periaortic or regional mesenteric lymph nodes. The pathology report was secondary adenocarcinoma in 1 of 9 left perisigmoid colon lymph nodes. There was no demonstrable residual carcinoma at the site of polypectomy.



Metastatic adenocarcinoma in regional lymph nodes.

Comment

The presence of benign and malignant components in the same polyp suggests that malignant change does occur in benign adenomatous colonic polyps.

Microscopic evidence of coexisting polypoid carcinoma and benign adenoma in the same polyp is rare, Spratt, Ackerman and Moyer[3] say that it virtually never occurs, a few cases have been reported from Massachusetts General Hospital, although by in large Castleman, according to Welch,[1] agrees that it is extremely uncommon to find this combination. Blatts[5] autopsy study showed 4 of 465 adenomas contained both benign and malignant epithelium morphologically with clear-cut invasion of the muscularis mucosae or the muscularis proper.

We thought it an interesting observation that tumor emboli were demonstrated in lymphatic channels in the polyp.

The presence of metastatic adenocarcinoma in regional mesenteric lymph nodes is proof that malignant adenomatous colonic polyps do metastasize.

The incidence of carcinoma in polyps 1.5 cm or more in diameter is known to be greater than in smaller polyps. For example, the incidence of malignant disease is under 1% in a polyp 1 cm or less in diameter. This may suggest that adenomatous polyps may indeed become malignant as they grow.

We certainly do not believe that all adenomatous colonic polyps become malignant but the incidence of transformation is high enough so that these polyps should be treated as premalignant or actually as malignant lesions dictated of course, to a large degree, by the size of the polyp.

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PUBLIC RELATIONS FOR THE DOCTOR

How The Physician Can Develop A Sound Program

REX F. HARLOW

Because of his function and position in today's society, a doctor practices public relations every hour of every day, consciously or not. He cannot hope for a public relations program worthy of himself, the important function he performs and the distinguished position he occupies, unless he gives it his intelligent personal attention.

It is a task the doctor cannot leave to others but must do himself—earnestly, carefully, and always with an eye to the future. Demands upon him to keep abreast of new developments in his profession are no greater than the demands that he do likewise with his public relations program. How he conducts his practice and how he carries on his public relations are but two parts of his operating system and both parts must function with full efficiency for him to be completely successful.

The doctor has a wonderful opportunity to reap rich rewards from a sound public relations program faithfully maintained and kept up-to-date, thinks Richard H. Blum, Stanford Research Institute scientist. In his book, *The Management of the Doctor-Patient Relationship,* Blum says that respect, awe, and anticipation of special power surround the person of the physician. The strength of this respect and awe are recognizable in the special efforts at politeness, humility, affability and deference which so often characterize the behavior of the adult patient in the relationship.

Patient relations are his most important relations, write Rollin Watterson and William Tobitt in the opening paragraph of their *Doctor and Patient,* a summary of a psychological study of the public relations of the physician and of medicine by Dr. Ernest Dichter. Medical public relations places emphasis on the individual human relationships between doctor and patient, say the authors.

In the Dichter report, considered by many doctors to be the most valuable public relations document presented to medicine, the psychologist places heavy emphasis upon the vital importance of the doctor-patient relationship, and particularly upon the necessity to keep it up-to-date. He makes the charge that medicine has lost its "historical heritage" of community devotion and leadership because the doctor-patient relationship has not changed to fit comfortably into the modern pattern of life. The charge appears to be justified. The doctor today who views himself and his work from the Olympian height once occupied by the family doctor is fighting a losing rear action. No longer can he lord it over patient, community, and all else in his orbit, disdaining to depart from the changed to fit comfortably into the modern pattern he can hardly even serve today as "father confessor." He is living in a different world of Medicare, medical specialists, group practice, rising costs, expanding fees, health insurance, scientific research, and a host of other factors unknown to the family doctor of old.

Rex F. Harlow, editor and publisher of The Social Science Reporter, was the first editor of PUBLIC RELATIONS JOURNAL. He has spent 55 years in public relations as a consultant, educator and author.

How can the doctor develop and maintain a sound public relations program in tune with the times, one that will contribute to his happiness and well-being and expand his usefulness?

His first task is to develop an attitude of genuine interest in public relations. Failure to do this is one of the greatest obstacles the average doctor has to overcome; frequently, lack of interest becomes contempt or antagonism. The doctor has to believe that organized public relations is a necessity in his practice today, that it is on a par with any or all the other activities in which he engages.

Organized public relations: that is the significant phrase in the above sentence. The doctor must gain a careful, realistic view of himself and his work in his community before he can construct an effective public relations program. A hit-or-miss or casual approach to the task will not do. He must ask himself: What kind of person am I? How much do I know about communicating with other human beings, especially patients, community leaders and others outside of my profession who affect me? What do the social and behavioral sciences have to offer me in this connection? Do I know the techniques and tools of public relations? If I do not, where and how can I get help in learning them well enough to serve my needs? These questions will need to be answered before an attempt is made to begin the program.

One requirement, already referred to, which must be met above all others is that the doctor have warm and satisfactory relations with his patients. He must earn and retain their confidence and respect.

Meeting the doctor-patient requirement will call for a keen appreciation and skillful use of communication tools and techniques. Without a sound communication system, the doctor will be lost. He must communicate to his patients his ideas and goals, his whole personality, as well as his explanations and instructions regarding the patient's medical and health needs. Social and behavioral scientists can help. They have long been concerned with communication as one of the great factors in human existence.

Frank Discussion

One of the biggest errors the doctor can make, as social science research indicates, will be to take for granted that his patient will always understand what he says. The doctor must not assume that his patient uses words just as he does; rather he must assume that unless great care is exercised, the patient will often misunderstand what he says. Also, it has been found that people admit into consciousness only those things which interest and promise to benefit them. They exclude those things they do not like or want.

Guided by these facts, the doctor will frankly discuss fees and render accurate, prompt bills, maintain attractive office facilities and hours, make house calls when requested to do so, keep careful patient records, be friendly, frank and cordial in his office contacts, use a follow-up system to reflect his continuing interest in the patient after the latter's visits to the office or his stays in the hospital, and otherwise carry on his practice on a high professional plane that pleases and satisfies his patient.

To these practical, down-to-earth requirements can be added Dichter's recommendations, that the patient's desire for continuity in his relationship with his doctor should be satisfied; the mutual desire of both doctor and patient for appreciation or affection should be satisfied; and the doctor should permit the patient to become an active and informed participant in his treatment, rather than a passive recipient of care.

Dichter has a particularly interesting recommendation on how to deal with the problem of the declining number and influence of the family doctor and general practitioner. He suggests a semantic approach: use a new designation, *personal physician,* to describe the doctor who diagnoses and treats the whole person, and to whom patients can come for psychological-biological counsel and continuing personal aid in *anything* relating to health. Helping to popularize the use and acceptance of the term personal physician should be a part of the doctor's relations with his patients, and with the public at large as well.

After making sure of the effectiveness of his relations with his patients, the doctor's next step will be to utilize his responsibilities and opportunities as a citizen. He will seek to pay his obligation to society by sharing his knowledge, training and talents. Here again he will leave as little as possible to chance. He will determine to the best of his ability his aptitude for public service, and he will look for ways in which he can expect to render the fullest measure of service and reap the

largest rewards. Measuring the amount of time he can allocate to outside activities, he will seek connections within his city, county, state and national medical societies that offer the fullest play to his talents. Without undue haste or pressure, he will establish himself as a progressive, constructive force in society movements which strive for an enlargement and deepening of public knowledge and acceptance of medicine as a powerful and indispensable social force. He will prove himself by working hard and unselfishly in the ranks.

Establish Contacts

While he is building a place for himself in the medical societies, he will also be establishing contacts with worthy community organizations and movements, selecting the ones whose goals, activities and achievements challenge his interest and in which he thinks he will feel most at home. He will study community needs and opportunities in terms of what is happening within the community and the world, and take his place with other thoughtful, dedicated citizens who are working for the public good.

In external relations activities the doctor will do well to heed the warning and advice of Blum. The physician, says the SRI scientist, has a special language, and by virtue of his social role and training also possesses specific beliefs and behavior not necessarily shared by others. He should seek greatest understanding from people of similar status. There will be the greatest degree of *mis*-understanding between him and lower-class people because of the great difference in backgrounds.

In all his outside contacts the doctor must remember that he is medicine's emissary and spokesman. On all matters of health, both public and private, he will be considered the authority, the person to whom people outside of the medical profession can turn for advice and guidance in making plans and carrying on activities relating to health. Modesty in speech and posture is necessary; at the same time, however, he must be the crusader and educator, one who helps others acquire a fuller and more accurate knowledge of the many values offered by medicine, and who teaches them how best to use that knowledge for the greatest good of the greatest number of people. An inner glow growing out of his love of medicine and dedication to its ideals and goals, demonstrated in his own person and attitudes, will do more to break down unwarranted prejudices and refute misinformed attacks against medicine than anything he will say, regardless of how carefully he marshals his thoughts and chooses his words.

County Society

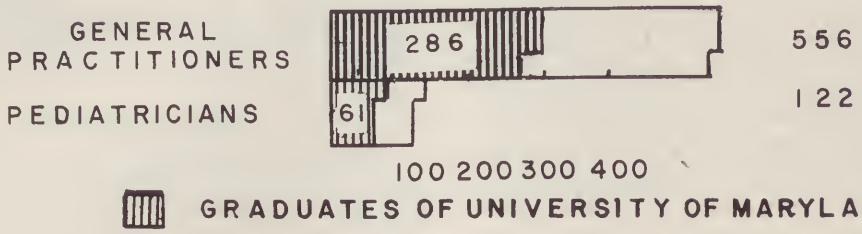
He may want to merge most of his external public relations activities with those of his county medical society. Leo E. Brown, director of public relations, American Medical Association, sees the county medical society as performing such public relations functions as: providing round-the-clock medical service; establishing mediation committees to arbitrate complaints about doctors; providing medical care for the indigent; publicizing home-town medical facilities; working with communication agencies—the press, radio, TV, etc.; promoting health education; taking a leading part in such community actions as school bond-issue fights, safety campaigns, hobby shows for senior citizens, and the like; stimulating progress in interprofessional relations; building better doctor-patient relations.

The basic burden of organizing and conducting his public relations program rests squarely upon the shoulders of the doctor, where it belongs. He can make as little or as much of it as he will; his is the choice. The quicker he realizes that through mastering the techniques of public relations he will contribute heavily to his own growth professionally as well as socially, the better off he will be. Acquiring the habit and skills of studying people, learning "what makes them tick," mixing with them, working with them, serving them, participating wtih them on behalf of worthy causes, will give him deeper, more accurate insight into all people, his patients included.

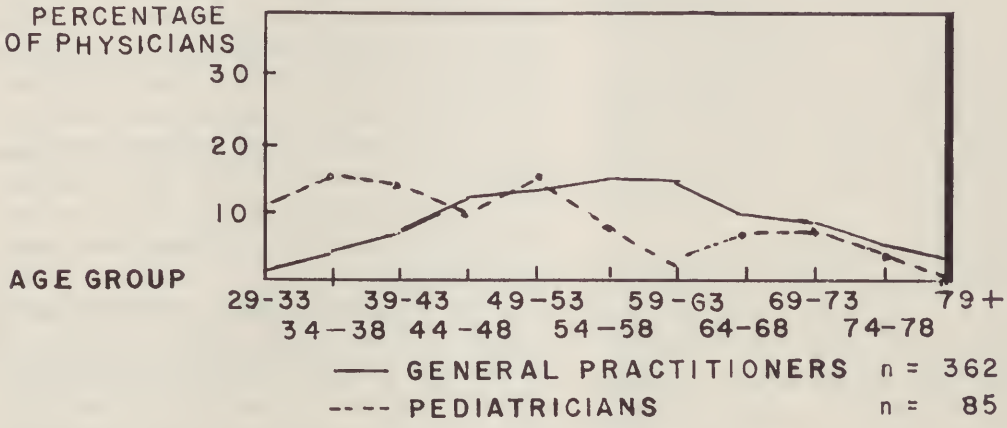
The doctor will have much to gain and little to lose by becoming a "first class public relations man." He will grow in stature as a man and a citizen. He will "win his spurs" in public service, take his place as a constructive force in society, contribute to the strength and forward movement of his profession, and enlarge and improve his practice.

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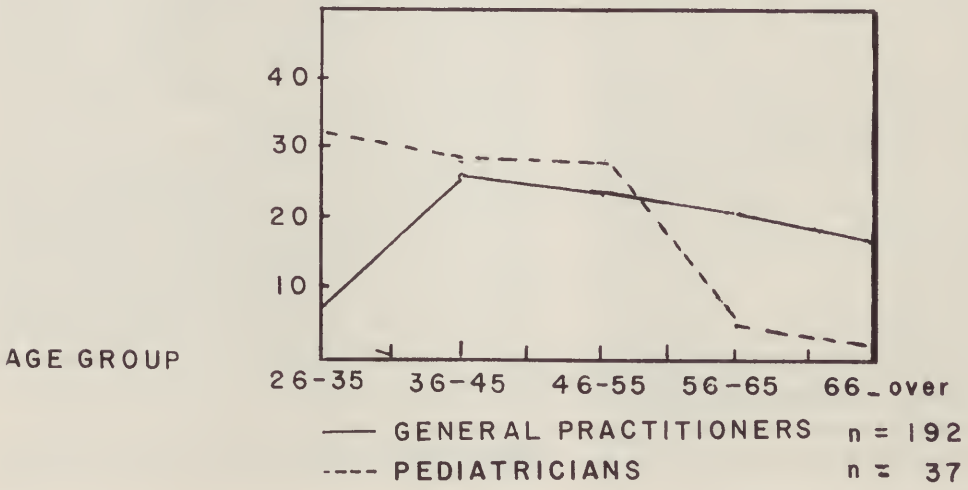
GRAPH I GENERAL PRACTITIONERS AND PEDIATRICIANS IN BALTIMORE, ITS SUBURBS AND FOURTEEN SMALL CITIES IN OFFICE PRACTICE IN 1966



GRAPH II PERCENTAGE OF PHYSICIANS IN FIVE-YEAR AGE GROUPS BY SPECIALTY IN BALTIMORE, INDEPENDENT CITY, 1966



GRAPH III PERCENTAGE OF PHYSICIANS IN TEN YEAR-AGE GROUPS BY SPECIALTY IN FOURTEEN NON-METROPOLITAN CITIES 1966



VING OFFICE MEDICAL CARE TO CHILDREN

OSCAR C. STINE, MD, Dr.PH
Associate Professor of Pediatrics, University of Maryland

The Problem

In 1940 in the United States there were 352 pediatricians and general practitioners to care for every 100,000 children.[1, 2] In 1961 there were 151 members of these two specialties caring for every 100,000 children. During this 21 year period the ratio of pediatricians rose from 7.3 per 100,000 to 16.3 per 100,000 children, but during the same time the ratio of general practitioners fell from 345 to 135 per 100,000 children.

The National Health Survey showed that only 20% of the children in the United States in the years 1959-1961 were seen by pediatricians.[3] This indicates that a decline in numbers of general practitioners has a major impact on the availability of office care for children. The purpose of this discussion is to examine the present supply of general practitioners and pediatricians in the state of Maryland.

One important alternative to meet the decreasing supply is to increase teaching resources in those areas preparing physicians to deliver office-medical-care for children. Another alternative is to develop new forms of office medical care which will use the skills of each physician more efficiently. In preparation for study of these alternatives we will examine the contribution of the present medical schools in Maryland to the supply of physicians for children in Maryland.

Review of Literature

In 1962 the Committee on Medical Care of the Maryland State Planning Commission showed that Maryland compared favorably with other states in the number of physicians per unit of population. They pointed out that these ratios may not be "a useful index as to a state's needs."[4] Shortages of physicians had been reported to the committee, which the committee interpreted as "distributional." They found that rural areas had low ratios of physicians to population. They recognized the poor indices of health of low income persons in Maryland but attributed these low levels to lack of motivation rather than the availability of physicians. Their data showed that the mortality rate for children under 5 in Maryland is higher than the national average. They did not study the supply of physicians to children as a possibility of distributional shortages.

The Maryland chapter of the American Academy of Pediatrics carried out a comprehensive study of health services to children in Maryland in 1945.[5] The study showed that only 16% of the children receiving medical care on an average day in Maryland were being seen by a pediatrician while 52% were being seen by general practitioners. The others were seen in hospitals' clinics or by other specialists. Care by the pediatricians differed from care by the general practitioner in the proportion of visits given to well children: 58% of the children in a pediatrician's office were well, while 30% of children in the general practice office were well. Less than 6.2% pediatric services were given in rural locations, while 21% of the general practice services to children were rural. Their data showed that 54% of the visits to a general practitioner's office were to patients under the age of 19.

The American Medical Association enumerated the physicians in Maryland in 1966.[6] Out of a total of 5986 physicians, 974 were in general practice and 485 were in pediatrics. Among these physicians serving children only 932 general practitioners and 217 pediatricians were in office practice. Thus less than 45% of the pediatricians in Maryland were in private or group practice. Inspection of the data for the standard metropolitan area of Baltimore showed that 95% of the general practitioners are in "solo, partnership, group or other practice," but only 31% of the

pediatricians are in this category of practice. This means that there are 599 practitioners available for the primary care of children in private offices in the metropolitan area, or 1149 for the entire state.

Comparing these numbers with those in the study of the Maryland chapter of the American Academy of Pediatrics reveals that after 21 years there are 153 more general practitioners and 148 more pediatricians in practice in the state of Maryland. In the same period of time the childhood population under age 15 rose from 434,000[7] to 993,000 in 1960.[8] The number of live births in 1940 in Maryland was 33,347; by 1960 there were 77,350 live births.[9] In 20 years the child population doubled. The number of pediatricians has tripled but the present number is only 19% of the physicians who are available in private offices to children for preventive services, initial evaluation, and treatment of the majority of childhood illnesses.

Enumeration of General Practitioners and Pediatricians, 1966

The trends in entering or leaving practice are reflected in the ages of physicians now in office practice. These trends vary according to the specialty and by geographic location. To understand this variation we selected for study the independent city of Baltimore, the suburbs of Baltimore and 14 cities that are not part of the large metropolitan areas for enumeration of physicians by age, specialty and medical school attended. We used the *Geographic Register of Physicians*[10] as the source of data.

The importance of general practitioners to the care of children in this state is apparent in Graph 1. If general practitioners spend half of their time in seeing children, they are clearly caring for a majority of children receiving private office care. The importance of the State University is obvious as a source of physicians giving personal medical services as well as being associated with locating physicians in this state.

The University of Maryland School of Medicine provided basic medical training for 57% of the general practitioners and 73% of the pediatricians. The Johns Hopkins University School of Medicine produced 3% of the general practitioners and 19% of the pediatricians. The proportion of physicians in these forms of practice graduating from the University of Maryland has remained about the same. By contrast there are markedly decreased proportions of medical graduates from Johns Hopkins in the younger age cohorts. In this sample there are only 5 pediatricians and 4 general practitioners who are graduates of The Johns Hopkins University who are under age 45.

Graph II shows the percent of general practitioners and the percent of pediatricians by age group for the city of Baltimore. The median age for general practitioners is 57 years. The median age for pediatricians is 47 years. Almost one quarter of the general practitioners in the city are over 65 years of age. The trend of decreasing numbers of physicians entering general practice is clear in the chart. The number of pediatricians entering private practice ranged from 9 to 14 for each 5 year age cohort.

Graph III shows the percentage of pediatricians and general practitioners by 10 year age groups in the suburbs of Baltimore and in 14 smaller cities. The decline in general practitioners in the younger cohorts occurred more recently than in the larger city. In these areas there are few pediatricians in the older age cohorts. Examination of the data reveals that the majority of pediatricians in the youngest cohort are in pediatric practice in the small cities.

The effect of physicians entering the armed forces requires further study. In 1966 there were no general practitioners in our sample under age 29.

Discussion

The increasing number of children in Maryland is only part of the increasing demand for medical office care for children. Since one-half of the visits to the pediatrician's office are for well children and only one-third of the visits of children to the general practitioner are for well child care, a shift to a larger proportion of child care by pediatricians will result in a higher number of visits per child per year. The national health survey of 1963 revealed that children in families with incomes over $7000 made almost three times more visits to physicians' offices than children in families with incomes under $2000.[3] This suggests that increasing annual incomes of families in the state of Maryland will be accompanied by further demands for office care.

The geographic distribution of pediatricians

and general practitioners indicates that the family in the large city will have increasing difficulty in finding office medical care for their children. In the same area it is clear that the retiring general practitioners will not be replaced by young pediatricians if present rates of entry to the private office of pediatrics in the city continue. With increasing case loads in a private practice more families accustomed to private office care will have to turn to emergency room and outpatient department services. The trend is already evident in the experience of many hospitals. Among the undesirable effects of increasing use of emergency rooms and outpatient departments, according to Bergman's observations, is the 50% of patients in a medical center's emergency room who did not have complete immunizations.[11]

At the same time that the supply of office services to children is decreasing, leading teachers of pediatrics are emphasizing the need for more attention to problems related to child development, emotional problems and the social problems of the families. A constructive response to the limitation of pediatric time in the face of social problems among private patients have been the incorporation of social work practice in a pediatric office.[12, 13] This is an example of how increasing demand for child health services might be met by development of new forms of practice among private practitioners.

The number of physicians serving in the armed forces is another factor in the reduction of numbers in the lower age cohorts. The large number of pediatricians in Maryland, and especially Baltimore, who are not in private practice indicates that persons who desire private physicians must compete with administrative, educational and research positions that are attractive to pediatricians. Modern medical education seeks to prepare its graduates to keep abreast of changes in the understanding of disease and of new developments in diagnosis and treatment which require critical evaluation based on principles of research. This effort tends to emphasize the laboratory and scientific aspects of training but tends to attract young physicians away from their plans for an office practice. To change the trend illustrated in our enumeration of physicians by age group, major changes in education must reveal equal intellectual excitement and greater personal rewards in giving optimum health and medical care.

Conclusions

One half of the general practitioners in the state of Maryland are 57 years of age or over. There are decreasing numbers of general practitioners in the younger age cohort.

Although the number of pediatricians in Maryland has tripled in 20 years, they only comprise 19% of the physicians in the state giving primary medical care to children. The greatest increase in the number of pediatricians was in the small cities. The rate of entry of pediatricians to private practice in the metropolitan area apparently reached a plateau below usual levels for the youngest age cohort.

Fifty-seven % of the sample of general practitioners and 73% of the pediatricians in Baltimore, its suburbs, and 14 smaller cities, graduated from the University of Maryland School of Medicine.

Continuing increase in child population and increasing demand for well child care will not be satisfied by present educational resources and patterns. The author pleads for an increase in teaching resources as well as efforts to develop new forms of office practice.

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Isadore Tuerk, MD, To Retire in July



Isadore Tuerk, MD

Isadore Tuerk, MD, Commissioner of the State of Maryand Department of Mental Hygiene, has announced his impending retirement.

A native of the Greene Street area of Baltimore now occupied by the University of Maryland Hospital, Dr. Tuerk attended P.S. School No. 1, Baltimore City College, Towson State Normal where he gained a teaching certificate, and was graduated from The Johns Hopkins University in 1930 with a BS degree in Biology with a Chemistry minor. In 1934, Dr. Tuerk was graduated from the University of Maryland Medical School and served his internship at Baltimore City Hospitals.

It was during his internship that contacts with patients interested him in emotional illness. In 1936 Dr. Tuerk became Assistant Psychiatrist at Baltimore City Hospitals and a year later entered State service as Assistant Psychiatrist at Eastern Shore State Hospital. He became Senior Assistant Psychiatrist there in 1939.

During the war he was commissioned a first lieutenant and served in the European Theater with the 80th Infantry Division. He was honorably discharged in 1946 and was awarded the Bronze Star. Following the war, Dr. Tuerk joined the staff of Spring Grove State Hospital as Clinical Director and became Superintendent in 1949. Governor J. Millard Tawes appointed Dr. Tuerk to the Department of Mental Hygiene as Acting Commissioner in 1959 and in May, 1960, he became Commissioner.

Following his retirement in July of this year, Dr. Tuerk plans to add to his 32 years of service to Maryland's mentally ill and retarded by continuing the Saturday alcoholic clinic at University Hospital—a program he has conducted for over 10 years; and by furthering his work with a group therapy session for parents of retarded children.

Dr. Tuerk's retirement is definitely a misnomer. He intends to divide his time between the aforementioned projects, and the Psychiatric Institute of the University of Maryland, the Enoch and Sheppard Pratt Hospital and private practice.

Outside of his professional life, Dr. Tuerk has a wide range of interests. He enjoys classical music, especially Beethoven, Bach and Brahms, and loves opera and the theater. He is a true Baltimorean in that he is an avid fan of the Colts and the Orioles.

Numbered among his organizational abilities stemming from his active teenage life is his fame as what he terms a "good" checker player which enabled him to run the checker concession at Carlin's Amusement Park. The concession involved about 10 checkerboards with Dr. Tuerk playing as many as 7 games simultaneously. If Dr. Tuerk won, the loser paid a nickel for the privilege of playing. If Dr. Tuerk lost, he dutifully presented the winner with a nickel cigar.

While attending The Johns Hopkins University's evening and summer sessions, Dr. Tuerk taught manual arts subjects at Pimlico Elementary School and coached the school's basketball team—another indication of his limitless energy and resourcefulness.

Dr. Tuerk was married in 1930 during his first year in medical school to the former Helen Blumberg, also of Baltimore. They have two sons, Jonathan, born in 1939, and Richard who entered the world in 1941. Jonathan is now in his second year of residency in Psychiatry at the Connecticut Community Mental Health Center in New Haven. Richard is an Assistant Professor of English at the University of California at Riverside.

Aside from Dr. Tuerk's already diversified life he expects to have another dimension added this summer when he becomes a grandfather.

Your MEDICAL FACULTY at Work

JOHN SARGEANT EXECUTIVE SECRETARY

The Executive Committee at its January 4, 1968, meeting took the following actions:

1. Agreed to obtain a legal opinion as to whether or not technicians could remove tissues or organs from cadavers when they are to be used for research purposes only, under the present law.
2. Agreed to work with representatives of the Attorney-General and the Bar Association to consider any legislative changes that might be necessary in connection with transplantation of human organs, in the light of recent international developments in this area.
3. Approved reappointments of physicians to the Medical Advisory Committee to the Red Cross Blood program.
4. Approved a list of physicians, one of whom will be selected by the Maryland Association of Medical Assistants as an advisor.
5. Agreed to obtain a legal opinion with respect to reinstatement of members who resigned because of the $50 assessment levied on February 20, 1965.
6. Referred to the Public Relations Committee a suggestion that the Faculty sponsor a statewide program on Health Care of the Poor.
7. Agreed to support Implied Consent legislation dealing with a 10% blood alcohol level to be considered the level at which a driver be considered unfit to drive.
8. Agreed to direct a letter to the Governor's Task Force on Executive reorganization urging the Faculty be given an opportunity to discuss any proposed changes in operation of the Board of Medical Examiners office.
9. Heard that a list of names for possible appointment to a special group to evaluate all health operations in the State was to be submitted to the Governor for his consideration.
10. Requested the Treasurer to recommend other ways to finance MEDIC operations now costing $20,000 per year from the Faculty's Educational Fund.
11. Authorized the expenditure of up to $125 from the Educational Fund for the purchase of the booklet, "Manual on Alcoholism," for distribution to Faculty members on request.
12. Approved the following personnel policy, the procedure currently being followed:

> That the Med-Chi Insurance Trust reimburse the Faculty for total salary and other expenses involved in the operation of the Trust, as defined in the Trust agreement; with the understanding that total salaries will be determined by the Faculty's Executive Committee in line with Faculty personnel policies.

13. Agreed to sponsor a program on Use of Blood Components, scheduled to be presented at The Johns Hopkins Hospital.
14. Agreed the Faculty should not take any position in connection with hospital medical staff rulings on the performance of diagnostic procedures, unless a specific request is received from a hospital medical staff.

The Heart Page

CHRIS PAPADOPOULOS, MD, EDITOR

A service of the Heart Association of Maryland

PROBLEMS IN PREVENTING INITIAL ATTACKS OF RHEUMATIC FEVER

MILTON MARKOWITZ, MD, LEON GORDIS, MD, ROMEO RODRIGUEZ, MD

In 1950, Denny and his associates[1] demonstrated that adequate treatment of the preceding streptococcal infection decreased the attack rates of acute rheumatic fever. These studies provided a rational basis for the primary prevention of this disease.

In an effort to reduce the incidence of first attacks, considerable emphasis has been placed on the need to accurately identify beta hemolytic streptococcal infections in children and recommendations have been formulated for the type and duration of therapy needed to eradicate these organisms from the pharynx.[2] While the incidence of acute rheumatic fever is declining, the disease has not been eradicated. In Baltimore, for example, during a 5-year period, 1960-1964, 263 patients were discharged from hospitals with a diagnosis of a *first* attack of acute rheumatic fever which met the Jones Criteria.

In order to assess the potential preventability of these attacks, the histories of these patients were analyzed with respect to the occurrence and management of the preceding respiratory infection. Such information was available for all but two of the 263 patients. These patients fell into three main groups:

Group A: No History of Respiratory Infection

Eighty-nine of the 261 patients, 34%, had no symptoms of a significant respiratory infection prior to the attack of rheumatic fever and therefore had no reason to come to the attention of a physician for treatment. Thus, it was not possible to prevent rheumatic fever in these individuals with asymptomatic streptococcal infections. Since this group comprised a third of the patients, it is clear that the occurrence of such infections seriously limits our ability to completely eradicate rheumatic fever.

Group B: Respiratory Infection, Physician not Consulted

Of the 261 patients with initial attacks of rheumatic fever, 172, or 66%, were associated with a history of a respiratory infection. Information with respect to medical care was available for 161 patients. Seventy-two, 45%, did not consult a physician at the time of their infections.

The reasons why these individuals did not seek medical care are not known. Thus, it is apparent that a large number of patients still are not brought to physicians for diagnosis and treatment of respiratory infections. This represents a second factor for the failure to eradicate first attacks of acute rheumatic fever and is a factor which is particularly important since adequate medical care can potentially prevent rheumatic fever in this group.

The relationship of the lack of medical care to rheumatic fever probably accounts, in large measure, for the fact that rheumatic fever is much more common in the lower socioeconomic group than in that segment of the population under continuous medical supervision. Efforts to diminish the rheumatic attack rate among this group of

From the Department of Pediatrics, Sinai Hospital of Baltimore.

patients requires public education, patient motivation to obtain medical care early, and increased availability of physicians. These factors invoke complex problems and cannot be immediately remedied. It is therefore unlikely that at the present time, an effective large scale program of primary prevention can be successfully carried out in Baltimore.

Group C: Respiratory Infection, Physician Consulted

Only 89 of the 261 patients, 34%, were seen by physicians for the respiratory infection which preceded the attack of rheumatic fever. Furthermore, throat cultures were performed in only 20 of these patients. Several studies have shown that it is often difficult to make a diagnosis of streptococcal pharyngitis on clinical evidence alone[3, 4] and that except in patients with scarlet fever, an accurate diagnosis can usually only be made by throat culture. Other studies have shown that streptococcal infections are often inadequately treated by physicians and represent still another important cause for failure to prevent rheumatic fever.[5, 6] The failure to make an accurate bacteriologic diagnosis of the respiratory infection will often result in improper treatment. Thus, in order to further diminish the attack rate of rheumatic fever, there is a need to increase the use of throat cultures by all physicians who care for patients with sore throats. Simple and inexpensive methods are available to do such cultures in the physician's office. It should be noted that only 7 of the 20 cultures were positive for streptococci. This suggests that either an inadequate culture was obtained or that the culture was taken after the use of antibiotic therapy was instituted. When a throat culture is done properly, a positive result will be obtained in over 90% of patients with acute streptococcal infection.

Summary

In summary, the histories of 261 patients with a valid diagnosis of acute rheumatic fever were reviewed in an effort to analyze the reasons why these attacks were not prevented. One-third of the patients had an asymptomatic streptococcal infection prior to their rheumatic attack and therefore were not within reach of presently available methods to prevent this complication. Another third had a symptomatic respiratory infection but did not seek medical care. In addition, a third of the patients developed rheumatic fever although they were seen by physicians for the preceding respiratory infection.

Since throat cultures were obtained from very few of these patients, it is possible that the presence of a streptococcal infection was not recognized and that appropriate antibiotic therapy was not prescribed. Thus, improved efforts to eradicate rheumatic fever will require community education, increased availability of medical care, especially for the indigent population, and physician education in the use of throat cultures and the proper therapy of streptococcal infections.

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THE 1968
ANNUAL MEETING—
A WELL-ROUNDED
MEDICAL
CONVENTION
APRIL 17 - APRIL 28

(See pages 6 and 7 for more information)

Baltimore City Health Department

ROBERT E. FARBER, MD, MPH, COMMISSIONER

SOME NEW DIRECTIONS

The *Weekly Letter to the Mayor* of December 8, 1967 following the inauguration of Thomas J. D'Alesandro III as Mayor of Baltimore City points up some new health department thoughts in improving the city's health. The letter is as follows:

"For some time this Department has recognized the necessity for redirecting its program to meet the health needs and aspirations of the changing population of the city. Hard core problems such as tuberculosis, venereal disease, unsanitary environmental conditions have served to be so intimately locked up with depressed social and economic conditions that conventional public health means of intervention have yielded but modest results. For this reason, we welcome the new and vigorous program of social and economic improvement and of equal opportunity which will be central to your administration. Improvements of this type will have beneficial health effects.

"The disadvantaged residents of the city who number more than 200,000 have a great need for public services to be visible and accessible. In particular this is true for assistance in maintaining housing standards and for basic health services. Your proposal for multipurpose neighborhood service centers will, when implemented, assemble public efforts on behalf of city residents so that the fullest benefits can accrue to Baltimore's citizens. The City Health Department will cooperate fully in achieving decentralization of services to the neighborhood level.

"The need for decentralization derives not only from considerations of effectiveness and efficiency. There must be greatly expanded opportunity for the neighborhood groups to assist in solving major problems which simply won't dissolve solely through government efforts. Increasingly, elderly persons or couples are left on their own. In times of temporary illness they may become completely dependent. When given no assistance by neighbors or family, permanent loss of home becomes a real possibility. The problem of teenage pregnancy, out of wedlock, is one which requires the attention and intervention of local neighborhood groups. As the multipurpose centers develop, the hope is that local neighborhood associations can acquire a skill in solving local problems of note. In this regard, the City Health Department will stand ready to provide speakers and all possible assistance to neighborhood associations as they come to grips with their local problems."

Robert E. Farber, MD
Commissioner of Health

Maryland Association of Medical Assistants

AWARDS RECEIVED

Two Maryland Medical Assistants received awards at the American Association of Medical Assistant's 11th annual convention in Los Angeles in October.

Dorothy Hartel of Baltimore was awarded a plaque for meritorious service and Mabel Young of Cumberland received an award for percentage membership increase in Allegany County.



Dorothy Hartel, left, and Mabel Young, officers of the Maryland Association, display awards received at the 11th annual convention in Los Angeles in October.

MARGARET SWANK ELECTED AAMA PRESIDENT

Mrs. Margaret Swank, Newark, Ohio, was installed as president of the American Association of Medical Assistants at its 11th annual convention, Oct. 11-15, Los Angeles.

A certified medical assistant, Mrs. Swank has been employed by Carl L. Petersilge, MD, a Newark pediatrician, for the past 15 years.

Other officers elected for 1967-68 were: Mildred Crawford, President-Elect, San Antonio, Tex.; Ruth Dize, Vice President, Norfolk, Va.; Pauline Hunter, Secretary-Treasurer, Phoenix, Ariz.; Betty Lou Willey, Speaker, Port Huron, Mich.; and Juanita Ainsworth, Vice Speaker, Dallas, Tex.

In a luncheon address during the convention, Milford O. Rouse, MD, Dallas, president of the American Medical Association, said the preservation and improvement of the physician-patient relationship will depend, to an increasing extent, upon the role the medical assistant plays in the doctor's office.

Dr. Rouse told the more than 900 medical assistants attending the convention that medicine has been accused of changing and destroying this MD-patient relationship, and of letting medical care become too automated and too impersonal by using the increasing demand for medicare service as an excuse. He urged both physicians and medical assistants to see that medical care remains personal care.

Two pharmaceutical companies—Merck, Sharpe and Dohme and Lederle Laboratories—announced renewed support of AAMA's education programs by each contributing $5,000.

Since 1962, Merck has supported AAMA's certification program designed to establish professional standards and goals for medical assistants.

For the second year, Lederle has contributed to the approval program which will establish guidelines for approving schools offering medical assistant training.

State of Maryland

Department of Health

WILLIAM J. PEEPLES, MD, MPH, COMMISSIONER

Funds Requested for Medical Assistance Payments

The $92.6 million requested by the Health Department for operation of the Medical Assistance Program during fiscal year 1969 includes $16,500,000 for payments to physicians, an amount double the 1968 appropriation. Of this sum, $7,500,000 is designated for payment for services in hospitals, based on "usual and customary" fees. The request is subject to approval by the Bureau of Budget and Procurement and by the Governor before being presented to the General Assembly. Last year's Medical Assistance Program budget request of some $65 million was pared to $45 million at final passage. The Governor has announced plans to request a $5 million emergency appropriation to make up the deficit in the current program.

HIGHLIGHTS

New Guide to Health Educational Aids Published

An updated edition of A GUIDE BOOK DESCRIBING PAMPHLETS, POSTERS AND FILMS ON HEALTH AND DISEASE has been issued by the Department's Division of Health Education. First published in 1960 and revised in 1964, the guide has been out of print for 6 months. The third edition was prepared in response to requests from former and potential users. This comprehensive reference contains annotations of free and inexpensive pamphlets and posters on various aspects of health and disease, with information on where they may be obtained. Films which may be borrowed from the Department's film library are summarized.

Past editions have been helpful to physicians, health personnel, educators, librarians, etc. Copies may be ordered from the Division of Health Education at $2, and lots of 100 or more may be purchased at quantity rates.

Dental Program Curtailed

As of December 1, at the request of the Governor, dental services reimbursable under the Medical Assistance Program were limited to acute needs. These include the relief of pain, control of bleeding, treatment of fractured bones, teeth and soft tissue injuries, treatment of acute infections, and repair of dentures. Fillings, multiple extractions, new dentures, fluoride treatments and preventive examinations were excluded. The cutback was necessary because the 1968 appropriation of $641,865 was exhausted in the first quarter of the fiscal year. The Department has requested $5,250,000 for fiscal year 1969 to cover proposed expansion of services and continued increase in usage.

Medic PKU Program "Top Rated"

In both size of listening audience and interested discussion following the formal presentation, the "Guthrie Screening Program in Maryland," presented recently on MEDIC by the Division of Mental Retardation, was the most successful in the two-way hookup's history, according to MEDIC's director. With 27 of the 32 MEDIC stations tuned in, the program was attended by 629 persons, chiefly public health nurses, nurses working in newborn nurseries and obstetrics, and nursing students and instructors. Purpose of the program was to familiarize nurses statewide with the method of performing the Guthrie Test for phenylketonuria, and the relationships between State and local health departments and hospitals charged with the implementation of the law enacted by the Maryland Legislature last year.

Chiefly responsible for the planning and coordination of the program was the Division's Public Health Nurse Consultant. Other Division personnel participated, as well as the Acting Director of the Bureau of Preventive Medicine, a technician from the Bureau of Laboratories, an audio-visual specialist from the Division of Health Education, and MEDIC's secretary from the Medical and Chirurgical Faculty.

Laboratory Expansion Urgently Needed

Technological advances in identifying and measuring environmental pollutants have outstripped the laboratory facilities of the Health Department. Increasing demands for determinations of air pollutants such as offensive odors and cancer-producing substances, for food contaminants such as copper and cadmium in oysters, and for sampling of sewage and water supplies, have overburdened the laboratory's present capacity. As these studies are essential and pressing, and completion of the new Central Laboratory is not expected before 1970 or 1971, immediate consideration must be given to expanding facilities in the interim. This will require the rental of considerable additional space for laboratory use.

Health Fair Exhibits Well Attended

An estimated 123,700 persons attended the recent Health Fair at the Baltimore Civic Center. One of the three Department displays was on air pollution; the second, a pictorial exhibit on the three major facets of public health—preventive medicine, medical services and environmental hygiene; and the third, entitled "Cigarette Country," depicted a cemetery with six grave-stones bearing four-line epitaphs satirizing cigarette advertising. This exhibit, created and designed by a staff member of the Division of Health Education, received much attention and press publicity. The displays are available for use in local areas.

In support of the Department's program for diabetes detection, the Bureau of Laboratories has assumed responsibility for quantitative glucose determinations by a rapid automated method on blood specimens collected in diabetes screening at the Health Fair.

Meat Inspection Legislation

Maryland's Legislative Council recently approved proposed legislation which sets standards for meat inspection and gives jurisdiction over the entire area of meat control to the State Board of Agriculture (University of Maryland Board of Regents). If enacted, this bill would remove the Health Department's authority to inspect meat packing facilities and exercise control over sanitation, and would create a second extenisve food inspection program in the State to supervise approximately 2% of the State's total food supply.

Since 1890, when the Health Department was charged with protection of the public food supply, human cases of animal-borne disease during the years have been reduced almost to the vanishing point. Salmonellosis, the principal disease threat of red meats, results primarily from improper handling—a situation which may occur at any point in the chain from the place of slaughter to the housewife's refrigerator.

The Department believes the inspection of food handling facilities, especially the points at which food is processed and packaged for and distributed to the consumer, is of primary importance, and best handled by persons whose only concern is protection of the health of the public. It also believes that supervision over food control, whether or not it involves inspection of meat, should be the province of the Health Department, and not an industry oriented function.

Parents of Children With PKU Compare Notes

Parents of children with phenylketonuria, who are being jointly followed by The Johns Hopkins Hospital and the Department, are sharing their experience and updating their knowledge of the disease and its management. Personnel from the Division of Mental Retardation are participating in the two meetings, held at the Hospital and led by the Assistant Professor of Pediatrics and his staff.

"Self-Help" Passes 100,000 Mark

More than 100,000 persons have graduated from the Medical Self-Help training program sponsored by the Division of Emergency Health Services. The free 16-hour program, developed by the U. S. Public Health Service and designed to prepare citizens to meet disaster situations when physicians' services may be unavailable, has been offered since 1963 through secondary school systems, both public and private, and through hospitals, community agencies, and other interested groups.

The course includes training in Radioactive Fallout and Shelter, Healthful Living in Emergencies, Artificial Respiration, Bleeding and Bandaging, Fractures and Splinting, Transportation of the Injured, Burns, Shock, Nursing Care of the Sick and Injured, Infant and Child Care, and, except where it is believed inappropriate, Emergency Childbirth. The Division hopes to reach at least one member of each Maryland family with the program.

Rehabilitation Notes

DOUGLAS G. CARROLL, MD, EDITOR

CARDIAC REHABILITATION PART III— *Follow-up after Myocardial Infarction*

DOUGLAS G. CARROLL, MD
Physical Medicine and Rehabilitation
Baltimore City Hospitals

Technical advances and new administrative (Coronary Care Units) aspects of treating patients with acute myocardial infarction are being vigorously and enthusiastically backed by the American Heart Association. In the preoccupation with technical matters and organization, the importance of the follow-up may be overlooked.

The recognition of anxiety and depression is important in the hospital; it is of even more importance during recovery. Myocardial infarction differs from many other common diseases in that by and large the patient either dies within a few months of the acute attack or recovers completely without any crippling neurological, mental or orthopedic disability.

Psychological Reactions after Myocardial Infarction

Depression, anxiety and fear are almost universally present and really are only abnormal when they persist for a prolonged period. These reactions may be easily overlooked since their principal manifestations may be lassitude, weakness, palpitation—all symptoms compatible with heart disease.

A second reaction is invalidism, occurring particularly in patients seeking escape from some intolerable situation, present prior to myocardial infarction. The heart attack turns out to be a socially acceptable reason for retirement from business or withdrawal from the rough and tumble of life.

Denial of illness is a third reaction. It is seen in patients of high intelligence who for various reasons are unable to accept a disability or the threat of sudden death.

The Recovery Process

Callahan et al[1] have recently described the general recovery process after an acute illness. "Role" is defined as a socially recognized pattern of behavior of persons in certain positions. The *sick* role relieves the patient of all other responsibilities and obligations. The sick person is expected to allow himself to be cared for by others, but at the same time he is expected to give up the sick role as soon as possible. The passive invalid-prone patient accepts the sick role eagerly and is slow to give it up. Patients who deny illness refuse to assume the sick role.

Most patients in the sick role react to their illness with a period of mourning and depression. Emotional interest is withdrawn from family and friends and centered on the patient himself. There is also hypochondriacal fussiness over small symptoms which might otherwise be disregarded.

The great majority of patients accept the obligation to throw off the sick role at the earliest possible moment. Patients normally want to regain some sort of recognized status in society. They want to love, to be loved and to be understood. Concentration on capabilities rather than on handicaps reenforces recovery process in most patients.

Generally there are three levels of relationship between the patient and the health team. During the acute life-threatening stage of the disease, the patient is completely passive and dependent on the health team. Following this, there is a relationship of guided cooperation when the patient is expected to increase activity gradually and accept advice and treatment without argument.

The final relationship is that of mutual partici-

pation. The patient is given more authority and with it more opportunity to disagree and to modify the advice and participation of the health team.

Factors Influencing Return to Work After Myocardial Infarction

Lewis[2] has studied a group of patients with congestive heart failure and has compared the characteristics of those who returned to work with those who became invalids.

The men who returned to work had only mild heart failure and were often able to discontinue digitalis. They had been employed during the past five years, had a high school education or better, saw their physician regularly. These men were generally "white collar workers," but if a "blue collar worker" they belonged to a union.

They were unknown to welfare agencies, were optimistic, resumed off-job activities as well as sexual activities. Their families neither rejected nor over-protected them.

The man who did not return to work had none of these favorable aspects. Lewis is quite pessimistic as to how these latter patients can be helped to achieve vocational independence.

Compliance With Medical Directions After Discharge from the Hospital

Davis and Eichhorn[3] studied 400 farmers in central Indiana in 1955 and again in 1960 in an attempt to find out how well these farmers followed their doctors' directions.

Seventy-one percent of the patients with heart disease had arteriosclerotic heart disease, 16% hypertensive heart disease and the remainder had rheumatic, congenital or some other type. About 30% of the group admitted some discrepancy between the doctor's advice and their actual behavior. The patients tended to adhere to advice that involved the least amount of difficulty in effecting a change in activity.

Farmers who were very highly work-oriented tended to comply less well than those who had low work orientation. Hard work in itself seemed to be valuable to these people. If the doctor's directions conflicted with the patient's work habits, he disregarded the doctor's advice. Also, higher educational levels were associated with less compliance with physician advice.

Donabedian and Rosenfeld[4] studied patients who had been discharged from the hospital with definite recommendations as to future care. About 30% did not comply with any recommendations.

Summarizing the two above mentioned articles, there are four major reasons why compliance with doctors' orders was not accomplished:

1. Faulty physician judgment: The physician misjudged either the degree of recovery of the patient or the potentiality of the family to carry out directions. The patient arrived home and was either unable to perform at the expected level or the family was unable to supply the promised services.
2. Misunderstanding of Physician's direction: The patient was judged to understand what he was to do at home but in actual fact the patient did not understand. This failure of communication may result from the patient's stupidity, but this intellectual deficit should be recognized prior to discharge. This is not alway done, one reason being that the doctor does not make a real effort to see the problem through the patient's eyes.
3. Change in family attitude: The family changes its attitude or loses enthusiasm when it finds what is required to fulfill the patient's needs at home.
4. Complicated directions: It is essential for the physician to simplify directions to families. Davis' study showed that the greater the number of directions given the patient, the less likely he is to carry them out. This also applies to the number of medications given.

Summary

Significant advances are being made in the hospital treatment of patients who suffer acute myocardial infarction. Much less attention has been given to what happens to patients after discharge from the hospital. If full alvantage of the advances in Coronary Care Units is to be accomplished, more attention must be given to the care of patients after discharge.

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BELDEN R. REAP, SR., MD, JD, EDITOR

THE INCIDENT REPORT

The foregoing title may, to some, suggest a cloak and dagger paperback novel. To the defense attorney upon whose shoulders has fallen the burden of defending a lawsuit in which an incident report is involved, the title frequently suggests a courtroom nightmare—from which he can neither escape nor awaken.

Many years of experience with incident reports leads a defense lawyer to dread what he may find in them. Of course, the report is simply, at least in theory, a factual recitation of an event (the word "accident" is usually avoided) which involved, or resulted in, injury or damage to the person or property of a patient. Execution of the report is customarily the immediate responsibility of the supervisory personnel and will generally embody statements of those who are directly, or indirectly, involved in the matter including, where appropriate, witnesses of the event.

However, since many weeks, or more hopefully, months may intervene between the occasions when such reports must be prepared, these written records usually comprise a conglomeration of conjecture, hearsay, guesswork and fact. Moreover, the details are frequently obscured or colored by emotional, self-deprecatory statements through which nursing personnel and others involved seek absolution through confession.

While it is true that incident reports must be honestly composed and fully and fairly present the facts that are known, for example, about an injury sustained by a patient, nevertheless, admissions of guilt, or responsibility, either real or assumed, should not be included in these reports. Guilt and responsibility may very well be apparent, or be deducted from the facts presented, but such *conclusions* have no proper place in the incident report itself.

This is not to imply that the report should be slanted, distorted, evasive, or written in such a manner as to conceal facts or mislead one. Aside from the moral implications, such dishonesty, if discovered and disclosed in a court of law, can have disastrous consequences. Both judges and juries dislike being deceived.

It is interesting to note how frequently hospitals will engage in what is usually an exercise in futility in seeking to prevent opposing attorneys from procuring the incident report when such a report has been prepared. Almost invariably the report must ultimately be surrendered. It has been suggested when such reports must be prepared, that the hospital attorney be consulted directly by the hospital employees (nurses, etc.) involved and the relationship of the attorney-client being thereby established, the incident report becomes "privileged" and need not be revealed except with the consent of the hospital employee. Whether this device will accomplish the intended purpose will depend on the facts in each case, and should be "cleared" with both the hospital attorney and the governing body of the hospital.

At the very least, a firm and uniform policy covering preparation of these important records should be clearly established. Too, there should be initiated a strict program of educative quality control which should include a review of those reports three or four times a year with the hospital attorney. In this manner careless, inept, and improperly executed reports, which may constitute a legal hazard, can be detected and corrective measures taken to avoid pitfalls and prevent bad habits from becoming routine.

It should never be assumed that hospital employees, of whatever status, are capable of preparing incident reports without some type of assistance, surveillance, supervision, or review. Such assumptions have produced the defense attorney's nightmares to which reference has heretofore been made. Truly they cause Excedrin headaches.

BELDEN R. REAP, MD

State of Maryland
Department of Mental Hygiene

ISADORE TUERK, MD, COMMISSIONER
KURT GORWITZ, ScD, STATISTICS DIRECTOR

THE HOSPITALIZED MENTALLY SUBNORMAL

Accurate data on the number of mentally retarded is not available. However, it is commonly estimated that at least 3% of the population—or six million Americans and 110,000 Maryland residents, have a measurable intelligence quotient (I.Q.) of less than 70. Added to this number, every year more than 100,000 babies, including 2,000 in Maryland, are born mentally subnormal. In addition, many children who are born with normal intelligence become functionally retarded because of cultural, familial and socio-economic deprivation.

Five out of every 6 retarded persons are believed to have an I.Q. level between 50 and 69 and most are publicly identified solely through testing programs and special classes provided by the various school systems. Since only a small proportion subsequently come into contact with treatment agencies, it should be clear that the bulk of the adult retarded must be functioning, in some manner, as community members.

The American Association on Mental Deficiency recommends between 1.1 and 2.0 beds for the care of the mentally retarded per 1,000 total population. Based on Maryland's current population of 3.7 million, this would be equal to 4,100 beds. At the present time Rosewood and Henryton, Maryland's hospitals for the mentally deficient, have 3,100 patients and privately operated facilities provide less than 100 additional beds. Latest available data, for 1966 published by the National Institute of Mental Health, indicates that Maryland had .84 beds in these two facilities for every 1,000 residents and was 14.6% below the national figure of .99. Thirty-two other states had a higher ratio.

Although the number of beds in these two facilities has increased two-thirds in the last 10 years, Maryland's relative position has remained essentially unchanged. In 1956, it ranked 30th and was 18.5% lower than that year's national ratio of .90. In 1961, Maryland was reported to be 32nd with a bed ratio of 17.8% below the national average of .93. Current construction of a new hospital in the Washington suburban area will raise the ratio of beds to population slightly, but will still leave Maryland below the majority of other states. Construction at Rosewood is limited to replacement of existing units scheduled for demolition.

Under present conditions, it must be expected that the number of retarded in Maryland requiring inpatient services will increase by at least 100 per year. The immediate need therefore is for the continuing construction and staffing of additional facilities.

The ultimate solution is dependent upon five major factors:

1. Research into the causes and means of prevention of mental deficiency.
2. Expanded and intensified prenatal services for expectant mothers known to have a high probability of having a premature delivery since the incidence of mental retardation is very much higher among such births than among full-term deliveries of normal weight.
3. The success of Head Start and other programs to minimize the effects of cultural, familial and socio-economic deprivation.
4. Increased training and educational programs for the retarded to permit the maximum development of their potential.
5. The establishment and expansion of closely coordinated community centered facilities and supportive services, such as day-care centers, half-way houses, sheltered workshops, group care homes, small residential facilities and other suitable substitutes for hospitalization. These are presently nonexistent or functioning only on a minimal basis.


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Woman's Auxiliary

MRS. HARRY L. BERMAN, EDITOR

MONTGOMERY COUNTY

For the past 14 years, the Woman's Auxiliary to the Montgomery County Medical Society has made funds available to student nurses. This year, Mrs. Harley Williams, of Takoma Park, and Miss Janet Dimmer of Kensington, Md., both students at Montgomery Junior College, were recipients of Nursing Scholarship funds.

Mrs. Williams, a former air-line hostess, entered the nursing program last September and has earned a straight-A average. She, and her husband who is a student at the University of Maryland working for his doctorate in clinical psychology, are co-sponsors and advisors for the senior fellowship group at Northminster Presbyterian Church in Silver Spring.

Mrs. Williams was graduated magna cum laude from Millsaps College with an AB degree in the humanities, and was accorded the honor of being selected "outstanding senior girl." after receiving her master's degree, she plans to teach nursing.

Miss Dimmer is a graduate of Walt Whitman High School and was matriculated in the Nursing Program of Montgomery Junior College in September, 1966.

Her extracurricular activities over the past few years have included being a junior volunteer at Suburban Hospital, working in the school nurse's office, and she has been active in the Medical Careers Club. She was elected Homecoming Princess this year. She hopes to continue her nursing education toward a BS degree.

* * * * *

The monthly meeting in February will take place at the Olney Inn and will feature as guest speaker, Dr. Brian Cowley. The topic of his discussion will be "Deciphering the Adolescent."

PRINCE GEORGE'S COUNTY

The Woman's Auxiliary to the Prince George's Medical Society is emphasizing the society's drive for better health enlightenment by taking "Operation Lighted Lamp" as its theme for 1967-68. The group hopes, through the distribution of various printed matter, to become synonymous with the plea for improved health conditions in the minds of Prince Georgians.

Like its sister county, this group will offer two scholarships to high school graduates in June, 1968. Plans are underway to hold a luncheon-card party in March to raise funds.

The Health Careers Chairman, in cooperation with the County Board of Education is planning a Health Careers Day. Elaborate arrangements are in progress to encourage student interest in medical fields. The entire auxiliary membership is participating as hostesses, guides, information aides, etc.

BALTIMORE CITY

Fifty-eight auxilians of BCWS assisted at the three-day Health Fair in the Civic Center last November. Ruth Vyner's splendid effort in getting the girls out to work deserves enormous praise.

The Auxiliary's benefit, and only fund-raising activity this year, will be a luncheon-fashion show to be held on Monday, March 11th, at the Greenspring Inn. Spring fashions by Dorothy Hess will be featured.

ALLEGANY-GARRETT COUNTY

In keeping with the Health Careers theme, members of the Auxiliary to the Allegany-Garrett County Medical Society have compiled a group of slides representing all aspects of health work to inform young people about health career opportunities. The slides will be shown to high school groups to emphasize the needs and opportunities in the community. Also in progress are plans for a Health Careers Fair in March to be held in conjunction with the Public Schools Career Day.

winter 1968

DORSEY Season

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this issue: the cold in pregnancy...

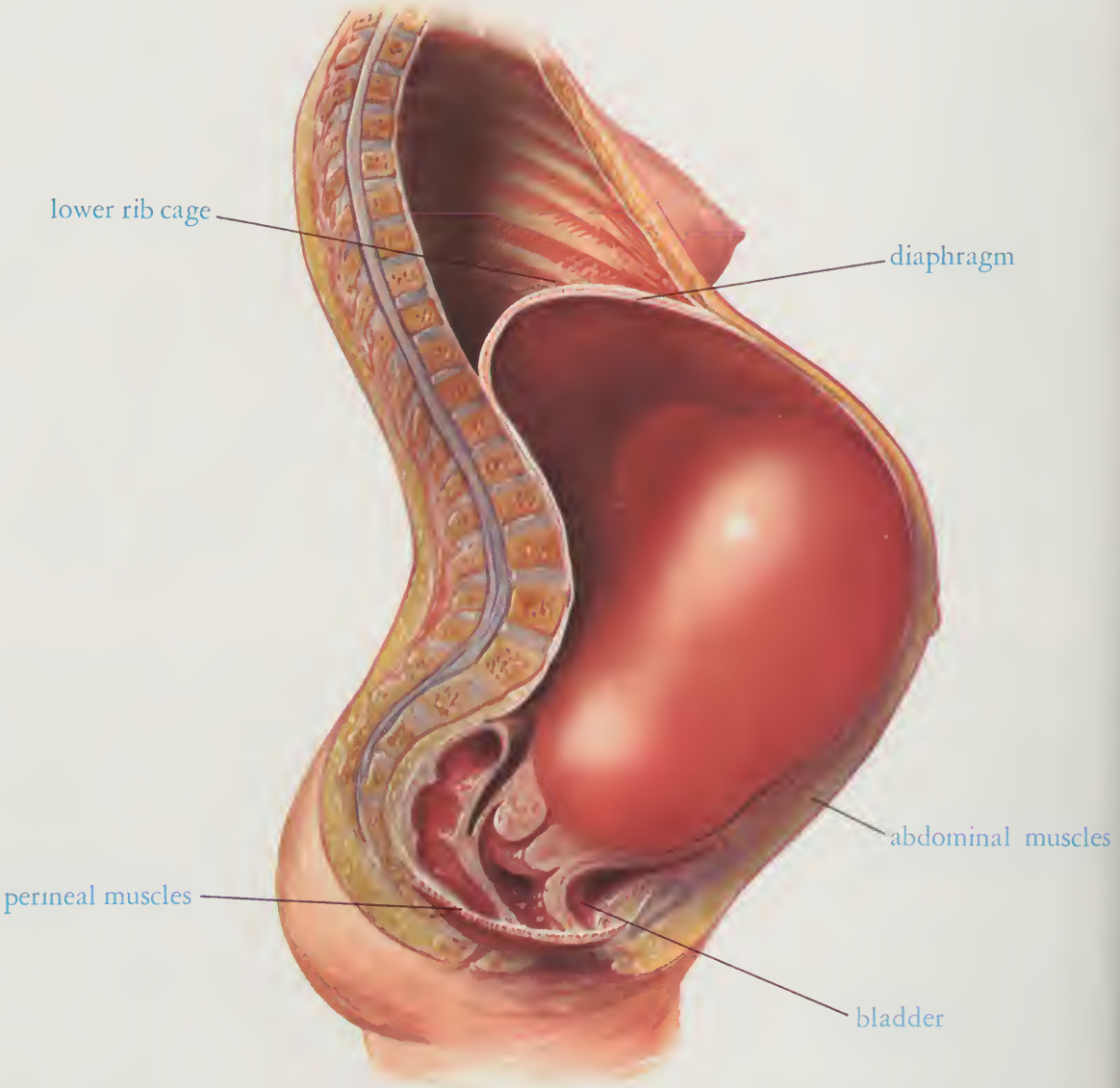
the cold in pregnancy

Frederick W. Goodrich, Jr., M.D.
Senior Obstetrician and Gynecologist, Lawrence and Memorial Hospital, New London, Connecticut

Since pregnancy and the common cold are both ubiquitous, it is not surprising that they often occur at the same time in the same patient. Incidence figures are hard to come by, but the chances are very good that any given pregnant woman will have a cold at some time during the nine months of her gestation. When she does, she will tell you that it is the worst cold she ever had. It seems to last longer and the symptoms are more distressing than they are in the non-pregnant.

For purposes of this discussion, the common cold is considered to be the well-known symptom complex which includes sore throat, stuffy nose, and a cough. Febrile states or extension of the disease process into the lower respiratory tree are not part of the common cold and will not be included in this discussion.

The clinical picture of a cold in pregnancy can be confused by a long-known physiological phenome-



non. Kiesselbach's area in the nose (on the anterior part of the nasal septum above the intermaxillary bone) becomes engorged, apparently due to hyperemia induced by the increased estrogen level which accompanies pregnancy. The amount of congestion can vary in degree from woman to woman. Some have very little congestion, others will have occasional nosebleeds from this area, still others will have symptomatic congestion to the degree that they will complain of having a "chronic" or constant cold.

Less well recognized is the occurrence of this type of hyperemia in any part of the nasopharyngeal mucosa, again in varying degree. Such swelling often produces a postnasal drip which, the patient will state, is present only when she is pregnant. Patients who do not have symptomatic congestion ordinarily, will find that when they do get a cold, the symptoms last much longer than those of a cold usually do. Occasionally, this hyperemia is responsible for closure of the medial end of the Eustachian tube; such patients will complain of "plugging" of the ears. Inspection of the ear drum will show a depression which confirms the presence of Eustachian closure rather than wax in the canal which is the patient's diagnosis. Symptoms related to this physiological congestion are more apt to occur in heavier smokers or those who have a history of allergic rhinitis, just as are the symptoms of the common cold. And when the cold does occur in pregnancy, the symptoms are worse because of the underlying congestion.

The pregnant woman with a cold is miserable for other reasons, dependent somewhat on her parity and the length of her gestation. As parity increases, so also does the relaxation of the abdominal and perineal musculature. The uterus, lying against a slack abdominal wall, and bearing down on relaxed perineal muscles, acts like a piston when the patient coughs, sneezes, or even blows her nose, pushing down on the bladder. Stress incontinence during colds is almost the rule.

As the length of gestation increases, so does the size of the uterus. As it grows, it pushes the abdominal contents above it and elevates the diaphragm. This results eventually in a lateral displacement of the lower rib cage, often to a point at which the patient will complain of soreness in this area. If such a

(Concluded on following page)

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patient has a cold, the coughing and sneezing will exaggerate this soreness. The diaphragmatic restriction caused by the enlarging uterus also makes breathing more difficult, particularly when the patient lies down. A cold compounds this difficulty.

Treating a cold in pregnancy requires two additional considerations. The patient should be told that the symptoms may last longer lest she become discouraged, and she should be reassured that the treatment will not damage the fetus. Although there are still some women who seem blissfully ignorant regarding matters of health (and these need to be cautioned not to take medication recommended by friends), most of our maternity patients are aware of the thalidomide tragedy. These women need constant reassurance that the symptoms of a cold can be treated, and that the medication is safe. Fortunately, many of the drugs which are of benefit have been in use long enough and widely enough so that such a statement can be offered. Occasionally one encounters a patient who is so anxious to avoid medication that she is extremely reluctant to take anything at all. Since cold is self-limited, it seems reasonable enough to give such a patient the choice and not to force drugs on her if she is obviously afraid of taking them.

The most distressing symptom of the common cold is the nasal congestion. This can be mitigated by the use of a decongestant which will help reduce the postnasal drip and the coughing caused by it. The kind of a cough which is described as a "tickling" in the throat and which is apt to occur when the patient goes to bed is usually due to nasopharyngeal congestion rather than inflammation in the lower respiratory tract.

There are many cough mixtures available. Most contain an antihistamine, a decongestant, and a cough "suppressant." Should cough suppression be desirable, it is important to remember not to use both a decongestant tablet and such a cough mixture as the patient would be getting a double dose of the decongestant. With some patients, the placebo effect of a cough syrup may be important and a liquid preparation might be substituted for an oral tablet.

For a sore throat, candy drops or lozenges at frequent intervals are soothing. It is not only unnecessary but unwise to use antibiotic lozenges or drops. The use of antibiotics in an uncomplicated cold is contraindicated and should be scrupulously avoided.

In summary, a cold in pregnancy is more severe and longer lasting. The treatment of the symptoms with local and systemic decongestants will make the patient more comfortable.

Apparently the cold is so common in pregnancy that it has received very little attention in the literature. References are almost non-existent and the few which are available add little to the common knowledge, are out-dated, or are not helpful. Thus the usual bibliography is not appended.



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Alcoholism Section

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

Folklore and Facts about Employees with Alcoholism—Part II

LEWIS F. PRESNALL
New York, N. Y.

(*Continued from December, 1967*)

Identification of the Scope of the Problem

The folklore of social stigma has described the alcoholic in terms of certain stereotypes. "Hopeless drunk," "no-good bum," and "weakling" are typical of these stereotypes. Obviously, no company can operate efficiently if its payroll is loaded with people who can be described in these terms. With only these pictures in mind, members of management have been entirely accurate in saying, "We don't have a problem with alcoholism in our company."

Folklore has also pictured alcoholism as a disgrace, and the alcoholic as having a defective-character condition which he could correct if he would only exercise his will power and drink in a controlled manner, "like all the rest of us responsible members of society."

Because of these folk beliefs in our culture, members of management have, until recently, felt that if they took constructive action regarding employees with alcoholism this action would reflect upon the company and the quality of personnel on the payroll.

The facts, however, are quite different from the folklore: Alcoholism is a widespread disease in our society; it affects approximately 1 out of 12 people who consume alcohol. No group of employees and no occupation in our culture is free from this illness. It is also a fact that only about 3% of the total number of people suffering from alcoholism in the United States are to be found in the "skid-row" population which usually contains the people who are in the late stages of alcoholism. The other 97% are found mostly in homes, offices, and factories. Their families are still intact, their health is not irreparably damaged, and they have regular jobs.

Therefore, when we refer to alcoholism in industry, we are talking about early- and middle-stage cases. Many of these workers with alcoholism still have drinking patterns that appear to the casual observer to be identical with the patterns commonly followed in our society by social drinkers. In fact, the social-drinking society provides alcoholics with a ready camouflage into which they can blend to avoid the penalties that social stigma inflicts upon them.

The frequency of alcoholism among employed groups has been found to vary from 1 to 8% of the total plant population. These figures are based upon case-finding in plants having effective alcoholism programs. The principal factors in this variation are the male/female ratio of employees, and the average age.

In old-line heavy industries, where the average age is relatively high—e.g., 42 years—and where less than 5% of the employees are female, one can normally expect to find that a minimum of 6-8% of the total employee population suffers from alcoholism in one of its stages. On the other hand,

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in a mercantile establishment—where perhaps 70% of the employees are female and the average age is around 35—the alcoholism frequency may run as low as 1%.

The picture of the "hopeless drunk" is also a part of unrealistic folklore. It is true that the recovery rates among advanced-stage alcoholics, commonly found among the older unemployed population, is extremely low. However, the prognosis is usually the same for any illness which has progressed without treatment over a period of 15-25 years.

On the other hand, the rate of recovery effected through alcoholism programs in industry has been between 50 and 70% of the cases treated. There are good reasons for this high rate: strong motivational tools are available in industry and we are dealing with less-advanced cases. Recovery, as the word is used by companies, does not necessarily mean that the employee has been continuously sober without interruption since he started treatment. Neither does it imply that patients have necessarily been transformed into models of emotional maturity in all instances. Relapse is common in this illness, as in some others. A high percentage of the patients treated will never return to drinking, but there are those who may have one or more relapses. Recovery, from the standpoint of the employer, means that the alcoholism has been sufficiently arrested, and even with an occasional relapse, the employee's work and attendance are not seriously affected. Companies are primarily interested in the general good health, the work performance, and regular attendance of employees. If these criteria are maintained at a respectable level, the employee is considered to be recovered as far as the company is concerned.

Unions are also interested in achieving a state of rehabilitation among alcoholics—the point at which the employee's work is satisfactory to the company and where union officials are not constantly put to the trouble of having to defend him against grievance and arbitration hearings where job security is at stake.

Company Policy

The discovery that all companies without formal programs have a policy regarding alcoholism comes as a surprise to many managers. It is an unwritten policy, but it is well understood by everyone who works in the company, including those individuals who suffer from alcoholism. This unwritten policy is created by the folklore of social stigma which everyone brings into the plant as a part of his preformed beliefs. If this policy were written in the usual company language it might read as follows:

> The company will pay an economic premium to employees for the successful concealment of alcoholism from the attention of management. This economic premium will be paid in terms of job security, promotion opportunities and fringe benefits. When the employee's alcoholism reaches the stage when it can no longer be concealed from the attention of management, his services with the company will be terminated.

It is impossible for a manager to state objectively that he has little alcoholism in his company as long as this unwritten policy exists. The economic and social rewards an employee with alcoholism receives for concealing early symptoms are enormous. The real reasons for absenteeism and poor or irregular work performance are disguised under alibis and diagnoses such as gastritis, upper respiratory infection, family troubles, and work pressures. If the person with alcoholism happens to be a salaried or executive employee, the economic rewards are proportionately greater and his ingenuity in concealing the problem from management's attention will be even more inventive. These factors prevent top management from receiving solid facts about the extent of alcoholism in the work force.

The only way that a company can remove or reverse this expensive and ridiculous effect of folklore is to deliberately establish constructive policies based upon facts. These policies then need to be implemented through sound procedures integrated with the company's existing personnel practices and health programs. Supervisors must be informed of the policy, instructed in the use of the procedures, and told how they may use the company's staff services in solving behavioral problems.

There is a tremendous potential advantage in industry. The problem can be converted into opportunity. Re-education and action can move in parallel lines. It is not necessary to wait until the emotional attitudes toward alcoholism of each supervisor and employee have been brought into line with scientific facts. At the community level,

this process may take 10, 20, or 30 years. With employee groups, however, this schedule need not delay action. Management has the power to establish policies and insist upon implementation through specific procedures. A company has only to take constructive action to induce supervisors to follow the procedures. Installation of any new program meets some resistance, but action does not require that the supervisor immediately change all his personal attitudes or prejudices.

For instance, if a company is installing a new cost-control and budgetary program, it is not necessary to educate every supervisor to be a careful manager of his own personal finances, nor to get him into the habit of balancing his own checkbook. The company simply describes certain procedures that must be followed. If the supervisor wishes to continue working for the company and he entertains hopes of promotion, he must follow the sound financial procedures that are explained to him by the company.

Doing something about alcoholism in a company is no different in this respect. Standard procedures are carefully tailored to fit the organization and the usual methods of management control are used. Unfortunately, the folklore on this subject has clouded our thinking and convinced many people that alcoholism is something quite different from other problems that yield to sound action and effective control procedures. If a company's disciplinary program is not corrective, it will not motivate anyone to change, including alcoholics. If normal communication channels are blocked, information about a company's alcoholism policy will fail to reach front-line supervisors in an effective manner.

Introduction of an alcoholism program which fails to work does not specifically indicate that alcoholism and alcoholics are hard to handle. It does show that the company's organization is not nearly as efficient as management had supposed it to be and this, in turn, indicates that a management problem exists. It must be dealt with before the company can deal effectively with anything, including alcoholism.

The Role of Labor Unions

Management is not the only group whose policies and procedures are dictated by folklore. Labor unions are also caught in the same trap of society's prejudices. Folklore makes it socially desirable for labor unions to respond politically, rather than humanely, toward union members having alcoholism. Labor representatives are put in a position where they must adopt the attitude of defending the employee's job security without giving any major attention to his future health or longevity.

In companies not having modern effective alcoholism programs, union representatives are not usually involved until the point is reached in the illness where job security is the primary issue. Even within some companies which claim to have alcoholism programs, we often find that union representatives are not invited to participate on the helping team until late in the disciplinary procedure. Corrective discipline is not applied because an employee has alcoholism, but because work performance or attendance is unsatisfactory. Often, no attempt has been made on the part of the employer or the union representative to get together at the first step of the disciplinary procedure where warning was given and an early attempt could have been made to motivate the employee toward diagnosis and treatment.

The unwritten procedures dictated by folklore actually put the immediate supervisor and the union representative into the same ambiguous position. In effect, they are helping to "kill the alcoholic with kindness" by postponement of action that combines firmness and understanding.

Employees with alcoholism are no less of a problem to union representatives than they are to management. Unions find that they can serve their own self-interest best when management and labor work together in identification of possible alcoholism in its early stages and in applying social pressure in such a way as to motivate the employee to seek help. Unions can also play an important part in the formal and informal educational process by which the cloud of folklore is dispelled and replaced with scientific facts in the minds of employees.

Procedures of Supervisors

The supervisors in a company that does not have a formal alcoholism program are in an awkward position. They are usually the first individuals, other than the employee's family, to recognize the early effects of alcoholism on behavior. They would like to do something about the situation, not only for humane reasons, but also be-

cause they recognize the enormous work problems and supervisory problems that result from alcoholism. In many cases, however, because of the misconceptions due to folklore, they do not recognize that alcoholism may be at the root of all the trouble the employee's behavior is causing on the job. At the same time, the supervisor often knows the employee personally. He hesitates to speak with him about a problem that folklore encourages him to believe is "personal." The supervisor often attempts to correct the condition when he is irritated and angry. He may make half-hearted attempts to apply standard disciplinary procedures. In the periods between these abortive attempts, the supervisor talks to the employee in a moralistic tone. The employee has encountered such moralizing so often from his spouse and friends that he is an expert at controlling the interview. The supervisor's efforts will produce no results and, as the illness progresses, the employee's record may show that the supervisor has given him 10 or 15 "last chances" before actual discharge.

Part of the supervisor's ambivalence is caused by the fact that management does not feel that alcoholism is a serious problem in the company. If a supervisor has 2 or 3 suspected alcoholics in his work group, he may be afraid that if this comes to the attention of management, it will reflect upon his competence as a supervisor. Furthermore, the company has not really given him any guidelines as to proper procedures when he encounters this sort of situation.

Many supervisors think that if they are to do anything constructive about an alcoholic, they will be asked to talk to the employee about his drinking problem. This they hesitate to do because it seems an invasion of an employee's private life. Unless the employee is intoxicated or drinking on the job, the supervisor is reluctant to bring up the subject.

Now, in contrast to the effects of this folklore, the facts are quite different. An effective program on alcoholism does not require the supervisor to discuss drinking behavior with employees. The supervisor's responsibility is job performance, attendance, and, if necessary, the administration of standard disciplinary procedures. He will have no occasion to discuss drinking behavior with an employee unless it occurs on the job. The supervisor is not a doctor, neither should he be cast in the role of amateur diagnostician. He sees certain behavior on the part of an employee, but he does not know that the employee has alcoholism. It is not his business to know this. This is the province of the medical profession, which, alone, is qualified to diagnose an illness.

Any supervisor, whether he works for a company with an alcoholism program or not, is asking for serious difficulty if he permits himself to get into a discussion with an employee about whether he has a drinking problem.

If the employee is suffering from alcoholism, which is a progressive illness, he has had many years of experience in winning arguments on this subject. All of the skills that the alcoholic has developed through the years in winning these arguments will be directed against the supervisor and nothing will be accomplished in the way of helping the employee. Society, steeped in its folklore, leads the person with alcoholism to privately suspect that he is either insane or morally delinquent if he continues to drink as he does. Suppose he is a well-dressed, successful executive. Not for a minute will he accept society's erroneous opinion of him without a struggle. His alibi system is his only protection of self-esteem. If alcoholics were regarded as sick people, they would not need to behave in a manner that looks unintelligent to the rest of us.

In the 4 major points briefly covered here, treatment has not been mentioned, for 2 reasons. First, a good deal is known about effective treatment of alcoholism. Alcoholics Anonymous remains the most effective single bulwark with its form of therapy, but there are other methods. Anyone who is interested can readily inform himself on this subject by reading, attending one of the many Summer Schools of Alcohol Studies, through NCA's affiliatel councils in many cities, or through contact with professionals familiar with treatment processes.

Second, the purpose of a company program for employees with alcoholism is to remove the effects of social stigma. Once this is done, early cases are identified and properly motivated to treatment. At this point, the company's job is largely done, and the employee can then be referred to outside community agencies for assistance in rehabilitation. Follow-up after the employee returns to work will, of course, be part of the company program. Many company and union programs

have failed because they did not give adequate attention to the in-plant aspects of the program that I have been describing. In other words, everything in the company programs may be best understood as belonging to a pretreatment phase.

There is no such thing as an ideal company program. Each program must be tailored to fit the organizational structure of the company. One of the more certain ways to guarantee failure in this field is for a company to borrow the alcoholism-program pattern used successfully in another situation and try to adapt it with minor modifications to their own company.

A good analogy that may describe why this approach fails is to use the example of a doctor-patient relationship. Suppose one went to his physician and said, "Doctor, I am sick." Then suppose that without taking a case history or examining the patient, the physician took a bottle of medicine off the shelf and said, "Take some of this. I tried it on the last patient and it works fine." A doctor who works in this fashion, we call a "quack." The analogy is exact for alcoholism programs that are taken from the shelf of some other company's success and applied indiscriminately to another situation. Some companies may succeed this way, but the mortality rate of such programs is very high.

Conclusion

It should be emphasized that the problem in taking action with company programs is not the alcoholic himself, but the effect of the social stigma and current folklore upon company policies, procedures, customs, and attitudes. We know how to treat alcoholism, but we have often neglected the task of dealing with the effects of erroneous folklore. This is why NCA has a new professional consultation service designed to help employers tailor programs to their organizational needs.

If an organization takes appropriate steps to remove the effects of folklore, the problems of early identification and motivation of employees to accept help will be solved with greater frequency. Patients can then be referred effectively to local treatment resources.

By following this course of action, the general supervisory competence within the plant will be greatly improved regarding all types of personnel problems. An added fringe benefit resulting from a good alcoholism program is that many of the behavioral problems that cause so much trouble to industry, including such things as psychoneurosis, family problems, incipient psychosis, and even narcotic addiction will be diagnosed earlier and handled in such a way that the vitality and productivity of employees will be conserved.

Mr. Presnall is Director of Industrial Services, National Council on Alcoholism.

Presented at the Ninth Annual Western Industrial Health Conference San Francisco, Calif., Oct. 8, 1965.

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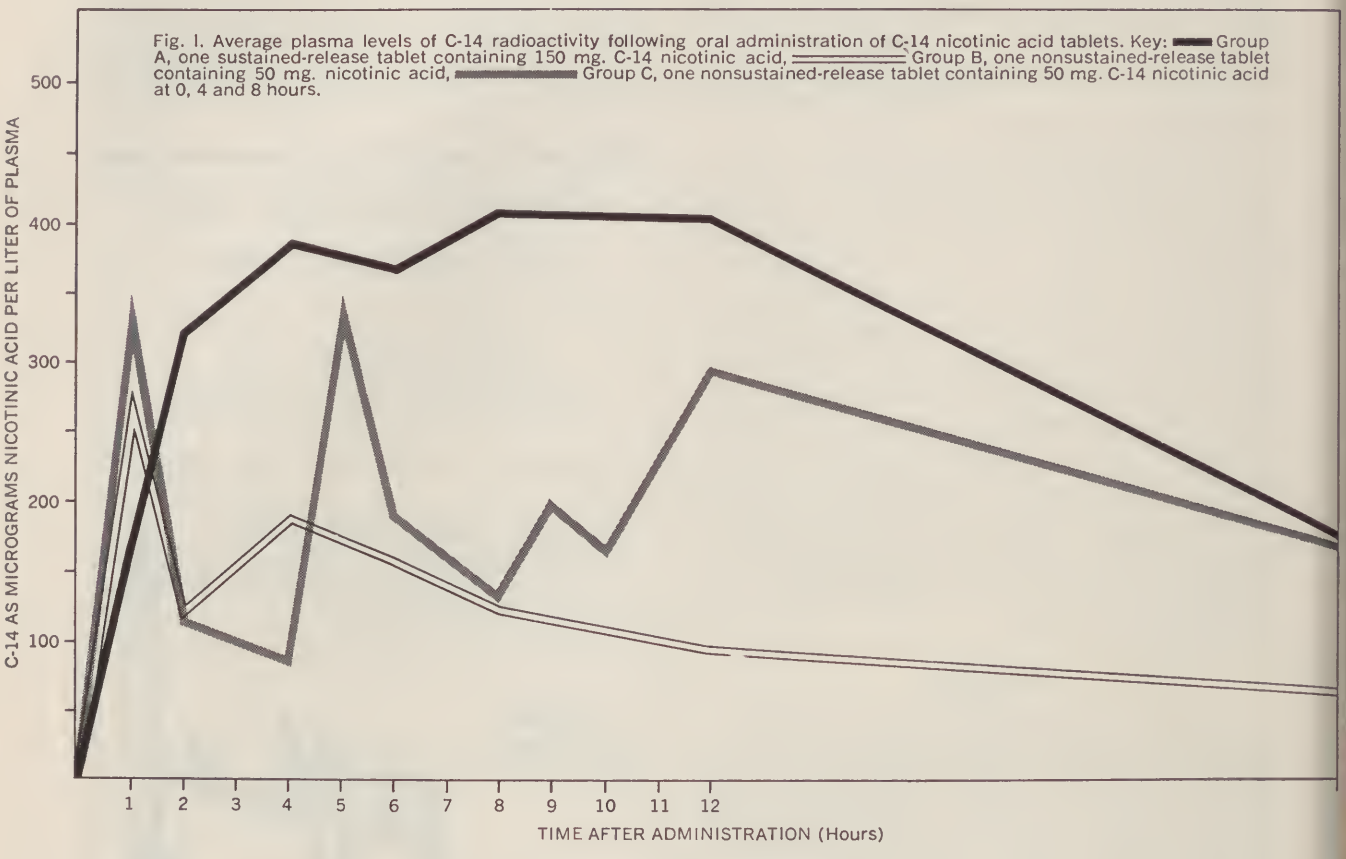
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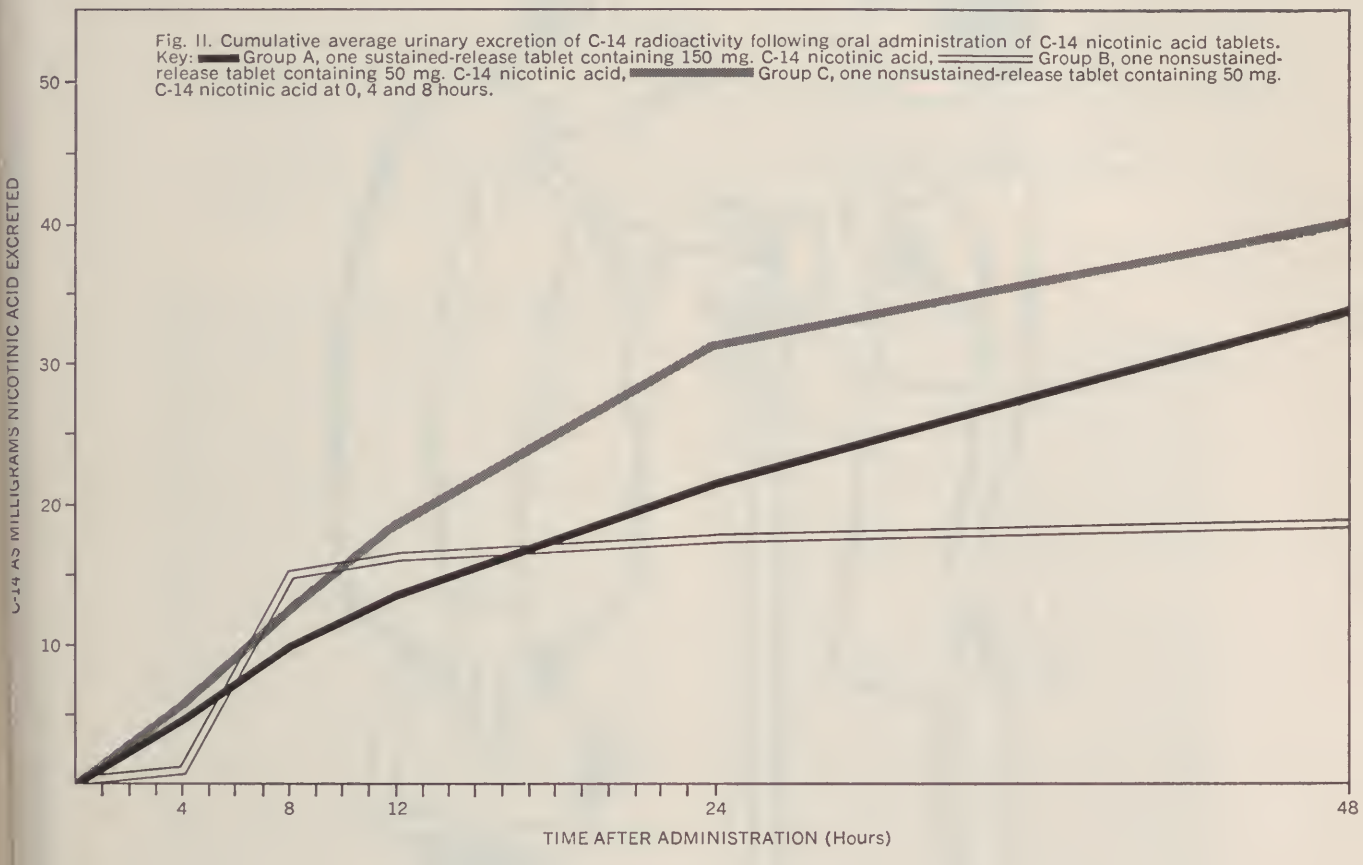


Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

ess confused and moody. Personal care, memory, motional stability, social attention improve. Fatigue, pathy and irritability are reduced.

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Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

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Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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CONFERENCE ON NURSING

Chairman, Nursing Liaison Subcommittee
JOHN F. SCHAEFER, MD

Forty-eight State Societies sent representatives to this conference. I was privileged to attend and speak for the Medical and Chirurgical Faculty of Maryland.

The program called for discussion of methods to strengthen professional relationships between Medicine and Nursing, provided an opportunity for exchange of information between the state medical society representatives, and evaluated problems common to the nursing and the medical professions.

Eleanor C. Lambertsen, RN, EdD, Director of the Division of Nursing Education at Teacher's College, Columbia University, was principal speaker for the morning session. She emphasized that the profession has defined the educational requirements for nursing but has failed to see completely what needs to be done. She stated that the young modern RN is criticized for inability to perform all the nursing duties that the older graduate performed. Modern techniques and procedures greatly influence what the young nurse can do after her formal training, and this depends on the medical staff at the hospital in which she trains and what it does. As an example, catheterization frequently was done "in the old days" in the patients room—under modern techniques, Foley catheters are placed in position in Surgery, and the hall or ward nursing job is maintenance. Dr. Lambertsen cited a parallel between specialization in Pathology, with its many subspecialties; and Nursing, where the student is influenced to specialize eventually as a nurse anesthetist, a Public Health nurse, a psychiatric nurse, a nurse in pediatrics, cardiology, intensive care, etc.

Following Dr. Lambertsen's excellent talk, comments from the physician representatives reflected the emotional turmoil associated with the provision of hospital nursing service.
Examples:

1. The nurse now is much more theoretically trained. This is better for the patient. The cost of her undergraduate training however should not be reflected on the in-patient's bill.
2. The nursing professional and the American Nursing Association are not seeing eye to eye; the Chief Nurse is against the programs but cannot do anything except comply with them; the AMA should do more to control nursing education.
3. The Diploma School is in danger of destruction by the Associate Degree programs. This should not be. The Associate Degree and the Diploma programs should furnish the general nurse, the "Indians;" and the

Sponsored Conference: AMA Committee on Nursing, for State Medical Society's Liaison Committee with Nursing. October 6, 1967. AMA Headquarters, Chicago, Illinois.

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four-year BS programs the "Chiefs." The BS degree program leads to nursing leadership, responsible independent position, and the ability to make sensitive decisions.

4. In New Hampshire, the State Medical Society and the Nursing Association requested and received approval by the state legislature for a nurse training subsidy of $600 plus tuition for the pursing schools, primarily to maintain the diploma school programs. This has accomplished its purpose, and has even led to an increase in applications for the BS program.

The afternoon session was devoted to illustrating how the Medical and Nursing professions can cooperate by delineating in specific areas the responsibilities of the registered nurse. The title of this session was "The Idaho Story," since Idaho is in the process of doing what the Faculty's Nurse Liaison Subcommittee already accomplished in 1965, with approval from the State Medical Society and the MNA. I was happy to be in a position to point this out to the assembly, and to offer constructive suggestions to Idaho for the implementation of its current endeavors.

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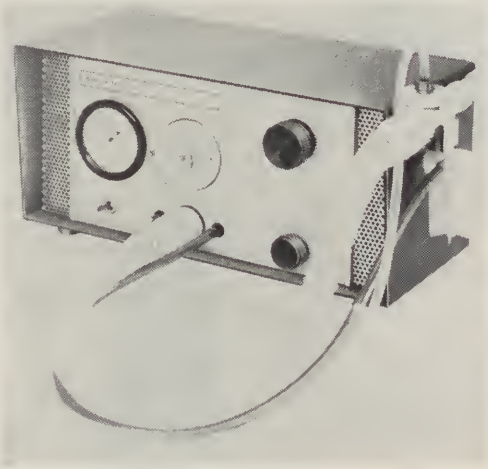
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Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

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• ATTRACTIVE RENTALS •

INTERFERON:

A NEW LANCE FOR THE ARMORY?

Parallel with advances in vaccine development came indications that the anti-viral agent interferon may yet become a weapon in the armory of clinical medicine.

Interferon, discovered by English investigators in 1956, is a protein produced by cells in response to virus infection and to some non-viral substances which are capable of entering the cell. It appears to act upon other cells to stimulate production of a protein which inhibits virus replication.

Ever since the discovery of interferon medical scientists have been fascinated with the idea that a wide variety of viral diseases could be prevented if interferon production could be stimulated to high levels within the human body. Efforts to "harvest" interferon from animals for use in human beings proved of no value: interferon is species specific, meaning that interferon from one species does not stimulate anti-viral activity in any other species.

Among substances being investigated as a harmless means of stimulating interferon production are: 1. a double strand of ribonucleic acid (RNA) stripped from certain viruses, which appears to jog cells into interferon production without causing disease, and 2. an industrially-synthesized giant molecule called pyran.

Although interferon produced within the body is much more potent than that passively injected, medical scientists are continuing efforts to obtain satisfactory interferon production in cultures of human cells.

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Baltimore, Maryland, 21225



"Yes, Doctor, the pain is gone."

'EMPIRIN'® COMPOUND with CODEINE PHOSPHATE gr. 1/2 No. 3

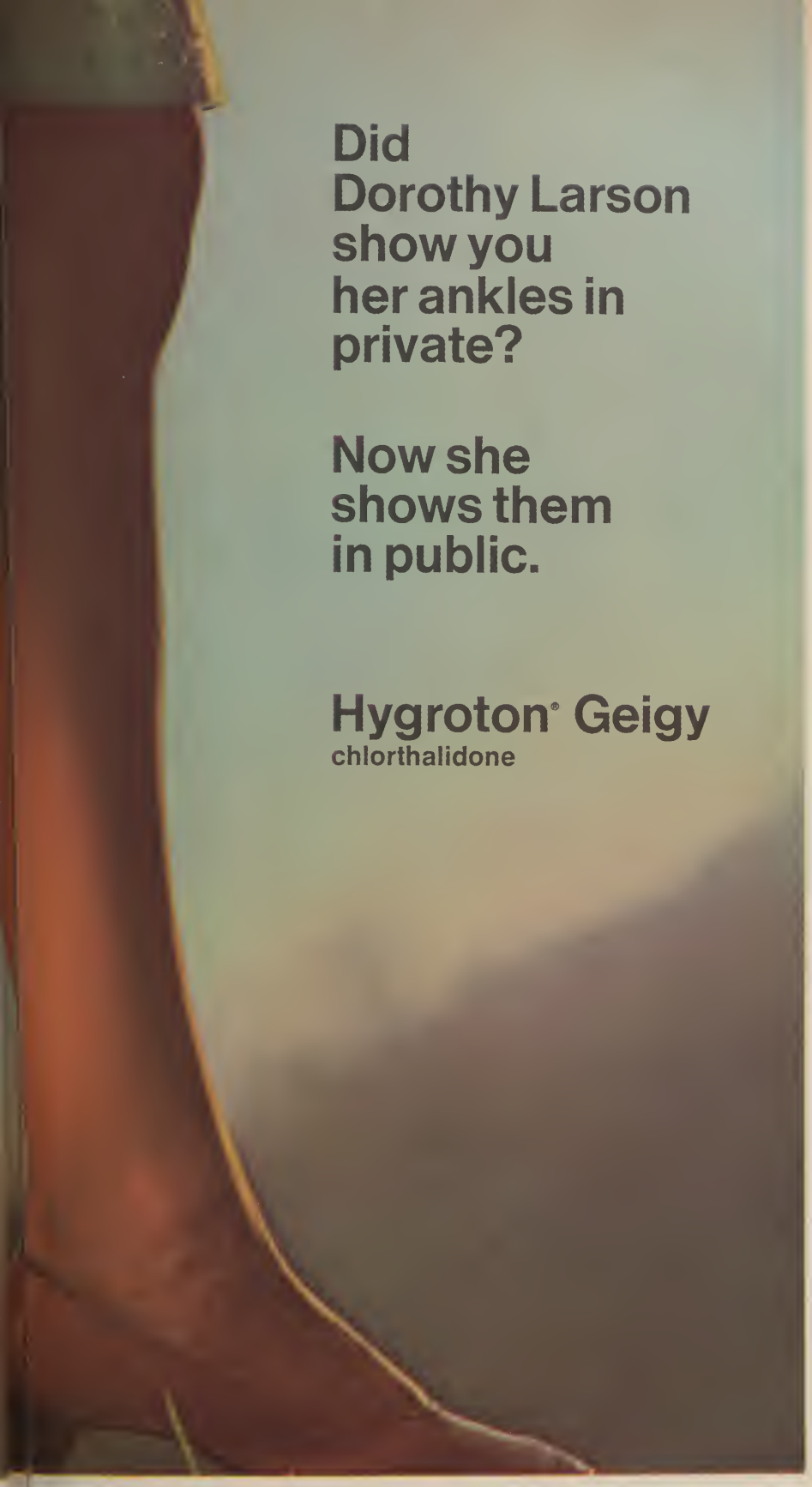
Each tablet contains: Codeine Phosphate gr. ½ (Warning – May be habit forming), Phenacetin gr. 2½, Aspirin gr. 3½, Caffeine gr. ½.

■ Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



Indications: Hypertension and many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Use with caution in pregnant patients, since the drug may cross the placental barrier and adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.
Precautions: Antihypertensive therapy with Hygroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension. Because of the possibility of p sion of renal damage, perio determination of the BUN is cated. Discontinue if the BU or liver dysfunction is aggr Hepatic coma may be prec Electrolyte imbalance, sod or potassium depletion may If potassium depletion shou cur during therapy, Hygrot be discontinued and potass supplements given, provid



Did Dorothy Larson show you her ankles in private?

Now she shows them in public.

Hygroton® Geigy
chlorthalidone

Your office examination confirmed Mrs. Larson's ankle edema.

You prescribed Hygroton—to get rid of the edema.

And you found that Hygroton is not only effective; it frequently costs less than other equivalent therapy.

A nice way to treat the Mrs. Larsons in your practice.

Hygroton therapy may mean troublesome side effects for some patients. A summary of the prescribing information is shown below.

tie oes not have marked oli-
ria
ke ecial care in cirrhosis or
ver schemic heart disease and
pa nts receiving corticoste-
ds CTH, or digitalis. Salt re-
ict is not recommended.
ve **Reactions:** Nausea, gastric
ta , vomiting, anorexia, con-
pa and cramping, dizziness,
ak s, restlessness, hyperglyc-
m yperuricemia, headache,
isc ramps, orthostatic hypo-
tension, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.
Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.
Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.
(B)R46-230-D
For full details, please see the complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

HY-5576

100 mg. Hygroton®
chlorthalidone

and new 50 mg. Hygroton



For the Dorothy Larsons in your practice, you can prescribe Hygroton either way.

Hygroton 50 mg. offers convenience for your patients who are halving the 100 mg. tablets or taking one every other day.

Geigy

Please see preceding pages for prescribing summary.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502



The full ¼ grain of phenobarb in the formula

takes the nervous edge off the pain ...helps bring out the best in codeine

Phenaphen® with Codeine

the only leading compound analgesic that calms instead of caffeinates

Each capsule contains:

Phenobarbital (¼ gr.) ..... 16.2 mg.
(Warning: may be habit forming)
Aspirin (2½ gr.) .....162.0 mg.
Phenacetin (3 gr.) .....194.0 mg.
Hyoscyamine sulfate .....0.031 mg.
Codeine phosphate.....¼ gr. (No. 2), ½ gr. (No. 3), 1 gr. (No. 4)
(Warning: may be habit forming)

Contraindications: Hypersensitivity to any ingredient.

Precautions: As with all phenacetin-containing products, avoid excessive or prolonged use.

Side Effects: Side effects are uncommon—nausea, constipation, and drowsiness have been reported.

A-H-ROBINS

A. H. ROBINS CO., INC., Richmond, Va. 23220

When the agitated businessman goes to work...

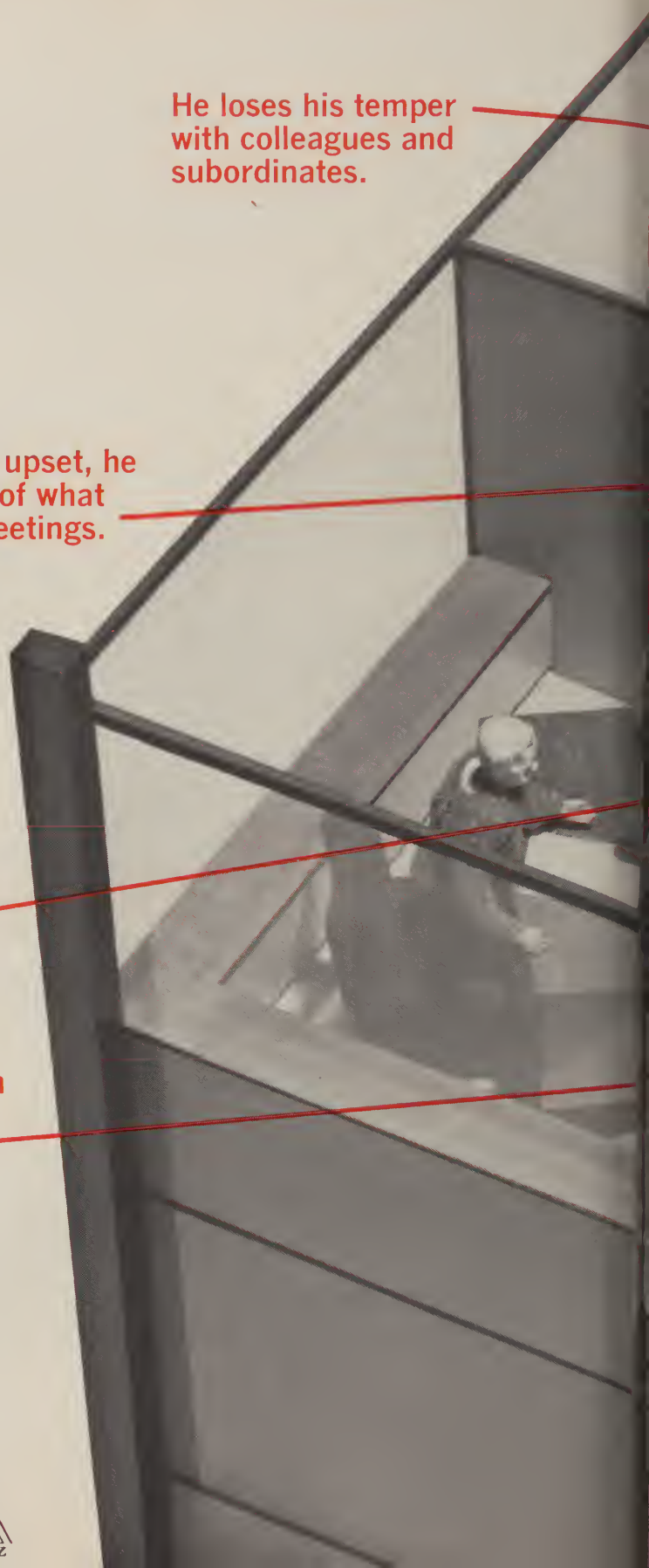
He goes home at night and takes it out on his family.

He loses his temper with colleagues and subordinates.

Emotionally upset, he misses half of what is said at meetings.

He is always fearful about his standing with the boss.

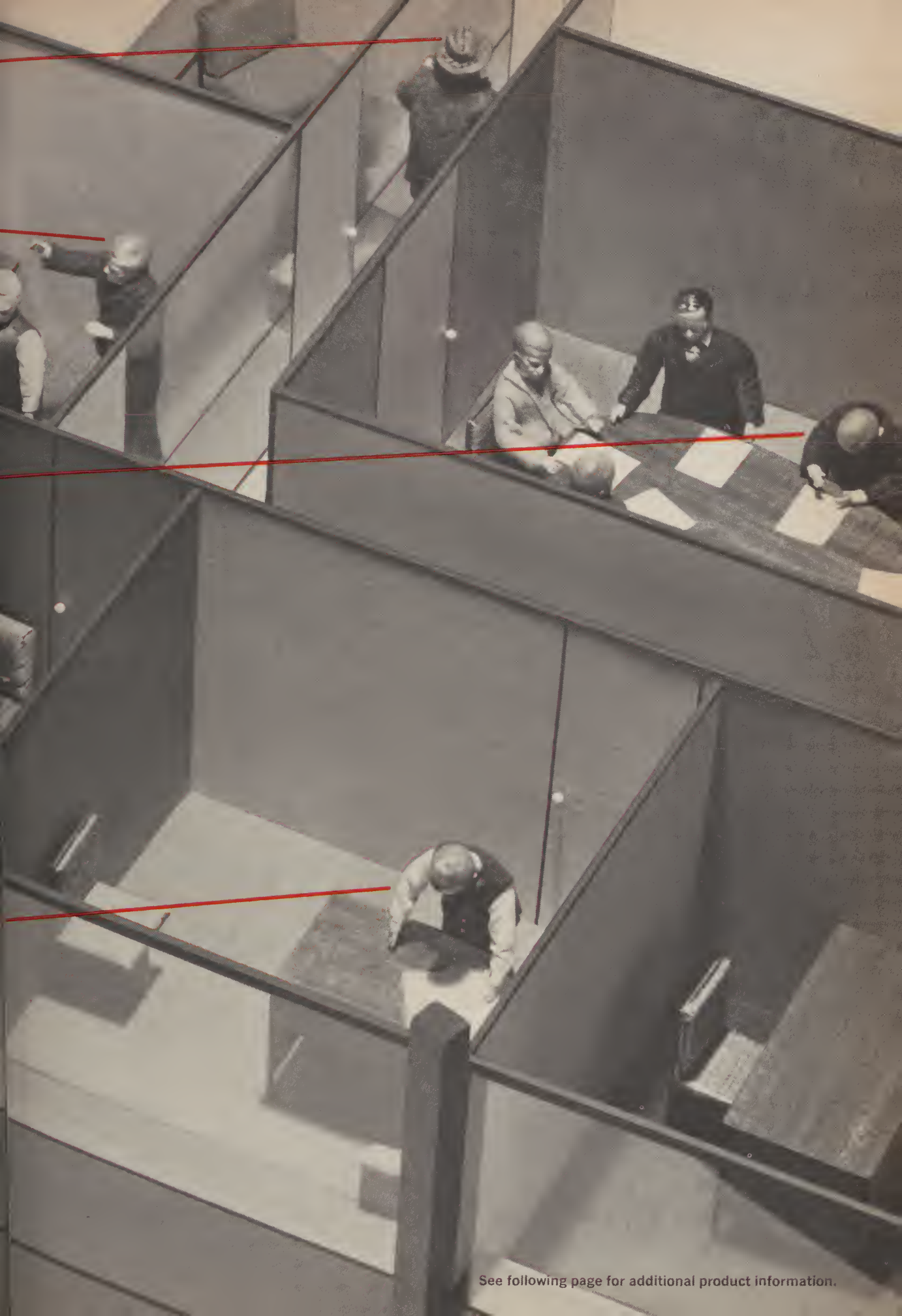
He just can't seem to settle down to his work.



for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ



See following page for additional product information.

When the agitated businessman goes to work...

Anxiety that *seriously interferes* with the individual's performance at work, at home, or in the community may be regarded as *moderate to severe* in degree.

Mellaril often recommends itself to the treatment of moderate to severe anxiety because it

- helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- often alleviates anxiety-induced somatic complaints
- frequently helps strengthen emotional resources
- helps the patient maintain realistic contact with environment, closer harmony with family

Thus, when you consider the anxiety moderate to severe...consider Mellaril.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

Before prescribing, see package insert for full product information.

for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ

mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 mg.
Aminophylline	130 mg.
Phenobarbital, Caution: May be habit forming...	21 mg.
Ephedrine HCl	16 mg.

FEDERAL LAW PROHIBITS
DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of water, 3 or 4 times daily.

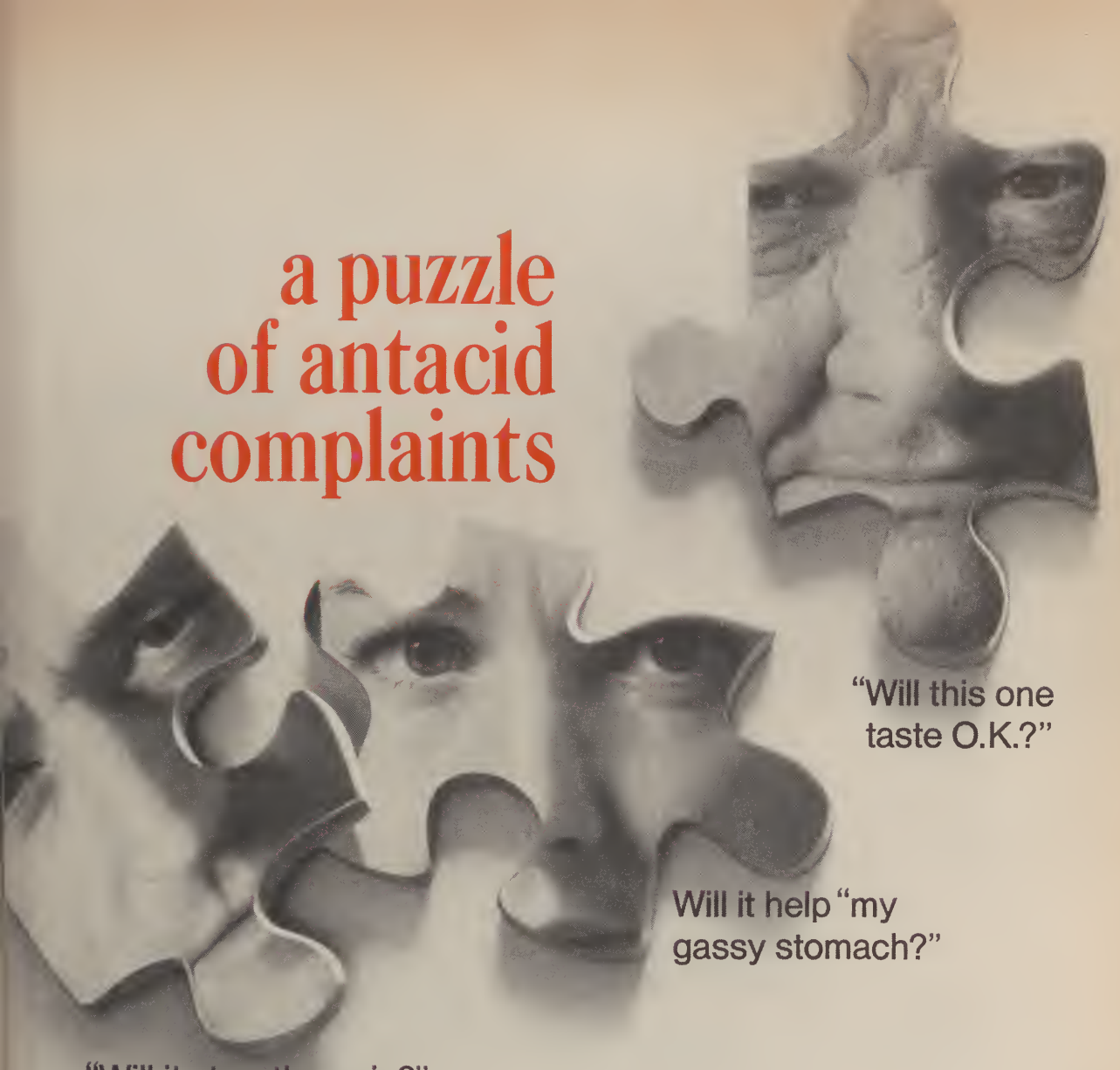
Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

WM. P. POYTHRESS & CO., INC.
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a puzzle of antacid complaints



Mylanta®

aluminum and magnesium hydroxide *plus* simethicone

a solution to peptic ulcer distress

Effective neutralization—
with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

Concomitant relief of G.I. gas distress—
with the proven[1] defoaming action of simethicone.

Prolonged acceptance confirmed—
in 87.5% of 104 patients after a total of 20,459 documented days of therapy.[2]

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg.
Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

References: 1. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966.
2. Danhof, I. E., Personal communication.

Stuart

Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

new evidence for TAO® (triacetyl-oleandomycin)

a macrolide antibiotic for the frequently seen respiratory infection in the office and for a problem pathogen* in the hospital.

*Staphylococcus aureus

study I[1]

Results of a 1967 in vitro—in vivo correlation study involving 116 patients with Gram-positive coccal infections in five institutions. All patients were given TAO prior to determining the susceptibility of the offending organism.

97.0%
of the organisms were susceptible to oleandomycin*

98.0%
of the patients responded favorably to TAO® (triacetyloleandomycin)

n some cases more than one pathogenic organism was solated from the patient.

study II[2]

Effect of oral therapy with TAO, erythromycin, and cloxacillin on the survival time of Rhesus monkeys after intravenous inoculations of lethal doses of staphylococci, phage type 80/81. (8 monkeys in each group)

conclusion:

*Under the conditions of this study and the doses employed, it was found that

TAO® (triacetyl-oleandomycin)

was far superior to erythromycin, as was cloxacillin, a bactericidal agent, and of particular interest, "...bacteriostatic triacetyloleandomycin was as effective or perhaps superior to cloxacillin in preventing lethal (staphylococcal, phage type 80/81) infection."

*It should be pointed out that results obtained in an experimental study of this nature may not necessarily be directly extrapolated to the clinical situation as it pertains to man.

O Rx Information

DICATIONS: Include streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections ıere adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents. **)NTRAINDICATIONS AND PRECAUTIONS:** Not recommended for prophylaxis or in the treatment of infectious processes ıich may require more than ten days continuous therapy. In view of the possible hepatoxicity of this drug when therapy yond ten days proves necessary, other less toxic agents should be used. If clinical judgement dictates continuation of erapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the st evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis e suspected, proper diagnostic procedures, including darkfield examinations, should be followed. In other cases in which ncomitant syphilis is suspected, monthly serological tests should be made for at least four months. Contraindicated in e-existing liver disease or dysfunction, and in individuals hypersensitive to the drug. Although reactions of an allergic ture are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions. When used in eptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or merulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant ection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the dication should be discontinued, and specific antibacterial and supportive therapy instituted.

ferences: 1. Isenberg, H. D.: Clinical Evaluation of Laboratory Guidance to tibiotic Therapy; Health Laboratory Science (July) 1967. 2. Saslaw, S., Carle, H. N.: Studies on Therapy of Staphylococcal Infections in Monkeys. Comparison of Cloxacillin, Triacetyloleandomycin and Erythromycin. Proc. c. Exp. Biol. & Med.: Vol. 125, No. 4 (Aug.-Sept.) 1967.

ROERIG Rx
J. B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017

For your impatient cold patients

Two sprays from NTZ Nasal Spray—and nasal congestion, rhinorrhea, sneezing are reduced for *immediate* comfort for patients with colds.

NTZ is more than a simple vasoconstrictor. It contains:

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction on contact.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.

NTZ is well tolerated. Used in a cold it may help prevent sinusitis by opening sinus ostia and permitting drainage. It may also be used in sinusitis to help establish drainage.

The spray is best used twice, the second a few minutes after the first, repeated every three or four hours as needed. NTZ is for temporary relief of nasal symptoms, and overdosage should be avoided.

Supplied: NTZ Nasal Spray, plastic squeeze bottles of 20 ml.; NTZ Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

Winthrop

Winthrop Laboratories
New York, N.Y. 10016



NTZ®
NASAL SPRAY

relieves
nasal symptoms
on contact



Baltimore City Medical Society

Zamoiski Auditorium, Sinai Hospital of Baltimore

THE ADOLESCENT

Friday, February 2, 1968, 8:30 P.M.

Participants

1. Emotional Problems of Adolescence.
   Kurt Glaser, M.D., Associate Professor of Pediatrics and Assistant Clinical Professor of Psychiatry, University of Maryland School of Medicine; Clinical Director Rosewood State Hospital, Psychiatrist, Adolescent Center, Sinai Hospital of Baltimore.
2. Medical Problems of Adolescence.
   Matthew Debuskey, M.D., Associate Professor of Pediatrics, The Johns Hopkins University School of Medicine.
3. Obstetrical and Gynecological Problems of Adolescence.
   Herbert L. Yousem, M.D., Director, Family Obstetric Clinic, Sinai Hospital of Baltimore; Instructor of Obstetrics and Gynecology, The Johns Holkins University School of Medicine.

(*All of the above physicians are functioning participants at the Adolescent Center, Sinai Hospital of Baltimore.*)

* * * * *

The Board of Directors of the Baltimore City Medical Society met at 1211 Cathedral St., Baltimore, Md., on December 12, 1967, at 4:30 P.M. The meeting was called to order by Harry J. Connolly MD, who welcomed the new members to the Board. These new members include John T. Chissell, MD, John N. Classen, MD, Edward F. Cotter, MD, Emmanuel A. Schimunek, MD, and Philip Franklin Wagley, MD. The minutes of the November 14th meeting were read and these were accepted as approved by the Board.

Edith Schoenrich, MD, and Miriam Van Gelder, MD, of the State Health Department presented problems related to the present nursing home situation in the State and the quality of

(*Continued on page* 127)



Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of Tofrānil and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before Tofrānil may be substituted. Initial Tofrānil dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, Tofrānil should not be used during the first trimester of pregnancy.
Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment with Tofrānil. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy.
Because of its anticholinergic effect, caution should be observed in prescribing Tofrānil for patients with increased intraocular pressure.
In rare instances, transient cardia arrhythmias have occurred in hyp thyroid patients and in patients re ceiving thyroid medication when Tofrānil was added to the regimen Imipramine may block the pharma cologic activity of guanethidine ar other related adrenergic neuron-blocking agents.
The drug is not recommended at t present time in patients under 12 of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, turbances of accommodation, swe ing, dizziness, weight gain, urinar frequency or retention, nausea an vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors rare cases of falling in elderly pa-tients, confusional states (with su symptoms as hallucinations and d orientation), activation of psychos schizophrenics and agitation (inc

When a milestone in life is marred by depression...



Often in the mind of the lonely, widowed, depression-prone individual, she's not gaining a daughter...she's losing a son. The occasion may be marred by such symptoms of depression as feelings of sadness, incapacity, helplessness and hopelessness.

In about 3 out of 4 cases, Tofrānil relieves symptoms of primary depression.

As maintenance therapy in primary depressive illness, it helps prevent relapse.

Although toxic reactions severe enough to require discontinuation of Tofrānil are uncommon, in patients with cardiovascular disease, thyroid disorders, increased intraocular pressure, or in those receiving anticholinergics (including antiparkinsonism agents), the special precautions listed in the Prescribing Information should be carefully observed. The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated.

Tofrānil® imipramine hydrochloride Geigy

hypomanic and manic episodes)
ich may require dosage reduction
d/or addition of a tranquilizer or
nporary discontinuation of the drug,
leptiform seizures, orthostatic
potension and substantial blood
essure fall in hypertensive patients,
rpura, transient jaundice, bone mar-
v depression including agranulocy-
is, sensitization and skin rash
luding photosensitization, eosino-
lia, and mild withdrawal symptoms
sudden discontinuation after pro-
ged treatment with high doses.
casional hormonal effects (im-
ence, decreased libido, and estro-
ic effects) may be observed.
opine-like effects may be more
nounced (e.g. paralytic ileus) in
ceptible patients and in those
ng anticholinergic agents (includ-
antiparkinsonism drugs).
patient Adult Dosage: Initially,
ng. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Tofrānil: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)46-850-C
For complete details, please refer to the full Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

If hypothyroidism leaves your patient feeling like this...

consider

LETTER®

(SODIUM LEVOTHYROXINE, ARMOUR) TABLETS

Synthetic Thyroid Replacement Therapy



Letter® provides all the advantages of the synthetically pure chemical sodium levothyroxine. Dosage is precise and potency is consistently uniform.

and

Letter® is micronized to provide maximum opportunity for full absorption and clinical response.

In addition Letter® is distinctively color coded with an identifying number stamped on each tablet to provide accurate dosage control.

Indications: Hypothyroid conditions. **Contraindications:** Thyrotoxicosis, acute myocardial infarctions unless associated with hypothyroidism. In hypothyroidism with hypoadrenalism coadministration of corticoids with LETTER® is recommended. **Precautions and Side Effects:** Excessive dosage may result in diarrhea, cramps, palpitation, nervousness, rapid pulse, sweating. If symptoms appear, discontinue medication for several days, then reinstitute at a lower level. Since myxedema patients with heart disease may suffer seriously from abrupt increases in dosage, caution should be exercised in adjusting dosage. **Dosage:** Generally, the initial adult dosage is 0.1 mg. daily. This may be increased in small increments every one to three weeks until proper metabolic balance is achieved. **Available:** Bottles of 100 tablets, in six potencies: 0.025 mg. (violet), 0.05 mg. (peach), 0.1 mg. (pink), 0.2 mg. (green), 0.3 mg. (yellow), and 0.5 mg. (white).

ARMOUR PHARMACEUTICAL COMPANY • CHICAGO, ILLINOIS

COMPONENT MEDICAL SOCIETIES

(*Continued from page* 123)

patient care for our senior citizens. The Board of Directors welcomed the opportunity to share with the State Health Department problems relative to nursing home care. It was pointed out that the Baltimore City Medical Society's role in this program is especially important since half of the nursing homes in the State are located within the confines of Baltimore City. Dr. Schoenrich pointed out to the Board that presently there are some conspicuous deficits in the program as it now stands. First and foremost, is the insufficient number of facilities available for the care of the senior citizen. Secondly, at the present time there is no adult foster home care program available. In addition to these obvious deficits, the great disparity in the quality of care available in various nursing homes was pointed out. It is also obvious that nursing home facilities tend to deterioriate with the passage of time and that more rigid controls and didactic standards should be established. Presently, the Federal standards and those required by the State for liscensure are preventative checks for this deficit but are still inadequate. The present standards for licensing a nursing home closely parallel Federal standards set forth for Title 18 patients. Like many other aspects of patient care, one of the prime deficits seems to center about the insufficient numbers of personnel available to man such facilities. Dr. Wagley suggested it might be possible to use model nursing homes as training centers for personnel to be subsequently used elsewhere. Dr. Schoenrich pointed out that a privately sponsored "Association of Principal Nursing Home Physicians" has been established and it is this organization's intent to upgrade the standards of nursing home care. This group of physicians have already set forth a didactic list of high ideals felt necessary for the operation of nursing home facilities. This group of physicians has the approval of the Medical and Chirurgical Faculty. It was suggested by Dr. Connolly that the Baltimore City Medical Society contact John Collins Harvey, MD, chairman of the "Nursing Home Advisory Committee" and that he appoint a member of the Baltimore City Medical Society to serve on this important committee.

Nominees for the Faculty's Community Service Award was discussed, and each member was asked to give this problem serious consideration and make their recommendations known prior to the next Board meeting.

The Professional Relations Committee reviewed several cases brought to its attention. These were discussed in detail, were acted upon and disposed of in the appropriate manner. N. Floyd Adams, Jr., MD, a member of the Baltimore City Medical Society since 1931 and presently retiring from practice, was recommended for emeritus membership.

The Policy and Planning Committee recommendation to hold Baltimore Medical Society meetings in various city hospitals was approved. In the future, Baltimore City Medical Society meetings will be held in selected city hospitals, the reason being to help increase attendance at meetings and allow the membership to visit those hospital facilities available in the city.

Under new business, the Board unanimously endorsed the reappointment of Robert Farber, MD to another term as Health Commissioner. This recommendation will be forwarded to Mayor Thomas D'Alesandro III in the immediate future.

The meeting was adjourned at 6:15 P.M.

Arthur E. Cocco, MD
Journal Representative

Brentwood Inn

FRENCH CONTINENTAL CUISINE

Smorgasbord Luncheon and Dinner every Tuesday . . . . .

"Home of Maryland's Internationally Famous Wine Cellar" . . . .

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THERAPEUTIC ABORTION

Arranged by Israel Zeligman, MD
Sunday, February 4, 1968, 2:00 p.m.

THE PILL

Arranged by Israel Zeligman, MD
Sunday, February 11, 1968, 2:00 p.m.

BLOOD BANK

Arranged by William E. Peterson, MD
Sunday, February 18, 1968, 2:00 p.m.

ANTI-CIGARETTE PROGRAM

Arranged by Elliott Michaelson, MD
Sunday, February 25, 1968, 2:00 p.m.

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MARYLAND PSYCHIATRIC SOCIETY

Francis McLaughlin, MD, *President*
Eugene Brody, MD, *Secretary*
Thursday, February 8, 1968, 8:30 p.m.

COMBINED MEETING WITH BALTIMORE PSYCHOANALYTIC SOCIETY

Criteria for Analysis in Adolescence. MARJORIE HARLEY, Ph.D., Supervising Analyst of Baltimore Psychoanalytic Institute.

PATHOLOGY SECTION

Edward L. Sherrer, MD, *Chairman*
William J. Hicken, MD, *Secretary*
Monday, February 19, 1968, 8:00 p.m.

MARYLAND RADIOLOGICAL SOCIETY

William Wallop, MD, *President*
Henry H. Startzman, MD, *Secretary*
Tuesday, February 20, 1968, 7:00 p.m.
New Auditorium of The Johns Hopkins Hospital
Dinner at 8:00 p.m., Sheraton-Baltimore Inn

The Radiologic Approach to Diagnosis of Arthritis. JACK EIDEKEN, MD, Department of Radiology, Jefferson Medical College Hospital, Philadelphia, Pennsylvania.

SECTION ON REHABILITATION

Julian Reed, MD, *Chairman*
J. Michael Coyne, MD, *Secretary*
Wednesday, February 21, 1968, 8:00 p.m.

Available Services and Facilities for Treatment of the Chronically Ill Patient after Evaluation. EDYTHE SCHOENRICH, MD, Chief, Bureau of Chronic Diseases, Maryland State Department of Health.

ANESTHESIA STUDY COMMITTEE

Joint Anesthesia Study Committee of the Baltimore City Medical Society and the Baltimore City Health Department.
Tuesday, February 27, 1968, 7:30 p.m.

Frederick County Medical Society

The Frederick County Medical Society held its election of officers at the Hotel Frederick on December 19th, during the society's annual Christmas meeting. The following doctors were elected:

Dr. Rex R. Martin, President
Dr. Ernest Dettbarn, President-Elect
Dr. Fred Baker, Treasurer
Dr. A. A. Pearre, Jr., Secretary

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WARNINGS

The public health struggle with venereal disease is far from won, as became apparent this year when the U.S. Public Health Service announced that gonorrhea is more prevalent in the United States now than at any time in the last 20 years. The proportion of penicillin-resistant gonorrhea strains also is increasing.

One problem appears to be a relatively large reservoir of non-symptomatic and untreated gonorrhea in females.

Other factors presumably related to disease increase are: lessened fear of venereal disease in the era of penicillin and "quick cures"; increased mobility of the population, including gonorrhea contacts; and, poor reporting of the disease by embarrassed victims and their physicians.

Penicillin resistance has been steadily on the increase among gonorrhea strains found normally in the United States. Some new strains, including some which are penicillin resistant, have been introduced to the U.S. by servicemen returning from Viet Nam.

Extensive research is underway to develop a reliable blood test which would enable physicians to spot non-symptomatic "carriers."

The Public Health Service also warned that a significant outbreak of A2 influenza can be expected during the winter season. Immunization and a booster shot two months later was recommended for the chronically ill, especially those with cardiovascular, renal, and metabolic disorders, as well as for persons more than 65 years old and persons in institutions.

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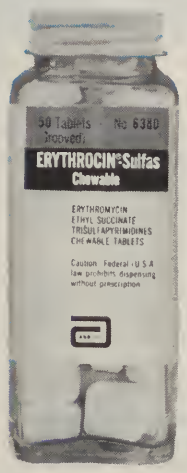
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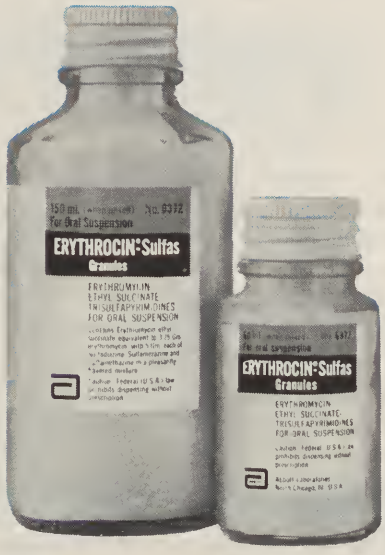
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1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

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Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

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Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

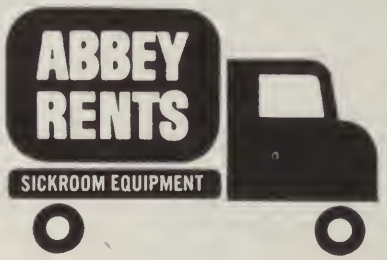
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JANUARY 26—1:00 P.M.

Neurosurgical Aspects of Strokes

Perry Black, MD, Instructor of Neurosurgery, The Johns Hopkins University School of Medicine

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FEBRUARY 2—12:30 P.M.

Burn Unit—Concepts of Burn Therapy

Thomas J. Krizek, MD, Chief, Division of Plastic Surgery, Baltimore City Hospitals

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FEBRUARY 9—12:30 P.M.

Diagnostic Problems
Panel Discussion

Moderator: Thaddeus E. Prout, MD, Chief of Medicine, Greater Baltimore Medical Center

Sponsor: Greater Baltimore Medical Center

FEBRUARY 16—12:30 P.M.

The Use of the Umbilical Vein in Diagnosis and Research of Problems of Portal Hypertension

John H. E. Bayley, MD, Chief of Surgery, Prince George's General Hospital

Sponsor: Prince George's General Hospital

FEBRUARY 23—1:00 P.M.

Pulmonary Embolism

Gottlieb C. Friesinger, MD, Assistant Professor of Medicine, The Johns Hopkins University School of Medicine

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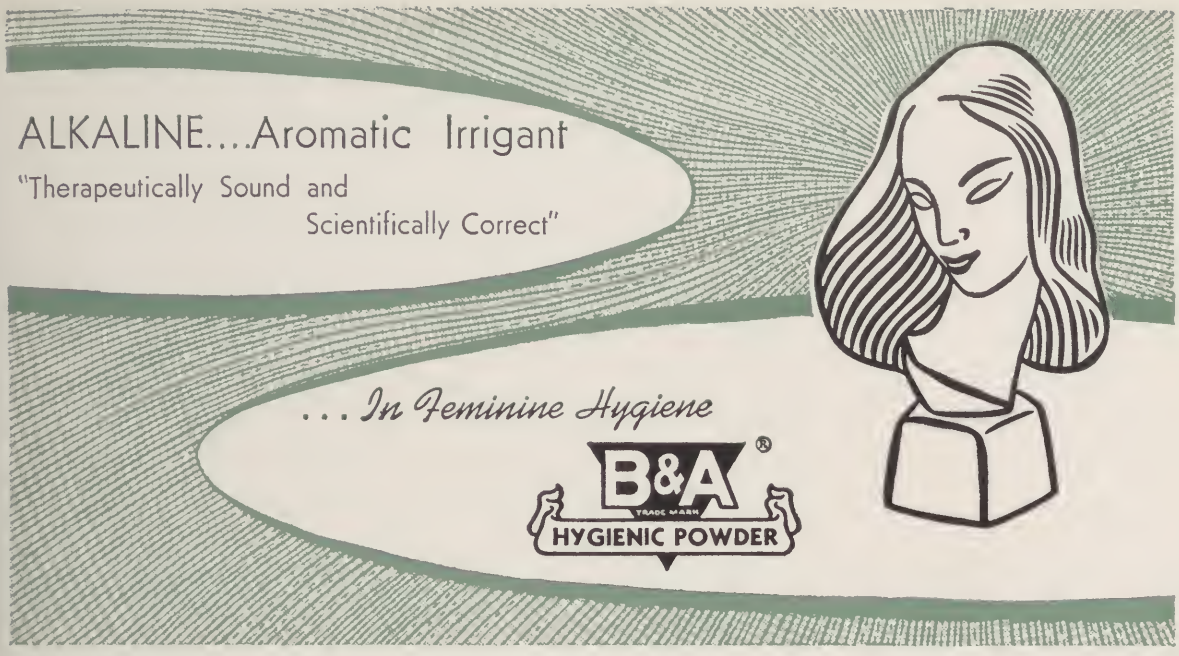
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"Early in 1953 Davis and Grand undertook a review of well established practices connected with the treatment of T. vaginalis infections. For instance, it had been accepted that an acid douche should be employed. This was based on cultural studies showing that when the pH was below 5 the organisms would die. They found that the commonly used vinegar douche with a pH of 3 showed no visible effect on T. vaginalis under the microscope in 15 minutes. Both citric and lactic acid were tested with similar results. Davis then recalled that in his early treatment of T. Vaginalis infections over 30 years ago he had had his first successes with alkaline preparations, and when he returned to their use the patients reported them more soothing than the previously used acid solutions."

(Am. J. Obst. & Gynec., 68:559, 1954)

Criteria for Cleansing Douche

"Daily douching often is a part of the treatment administered in dealing with T. vaginalis and since it is possible that the solution might contain agents that could hamper the regrowth of Doederlein bacillus, the following properties were said to be ideal.

1. It should contain a harmless, nonsensitizing detergent to remove mucous deposits and debris.
2. It should not contain any antibacterial agents, since the contact possible during douching would be so fleeting that anti-bacterial action could not be expected.
3. It should be acid in pH.

The 3rd property seems to be the most illogical and unimportant. If contact is so fleeting that antibacterial actions could not be expected, it would seem to follow that its acid quality would be of no consequence. Furthermore, acid solutions are irritating to the mucosa and oftentimes accentuate inflammation.

Actually, the value of a douche is generally conceded to be confined to its use as a cleansing and deodorizing agent. The encouraging results achieved with a detergent douche solution in treating infections of the vagina are probably attributable to the enormous normal recuperative powers of the vaginal tissues which have been under-estimated as a factor in the restoration of normal physiology.

Therefore, simple cleansing of the vagina with a non-irritating, mildly alkaline douche which is soothing to the vaginal mucosa and which penetrates and flushes out the dead organisms, debris and mucinous materials frequently enables the physiological processes to overcome the infection."

Charles B. Marek, M.D., Chief of Gynecology; Bon Secours Hospital: personal communications August 11, 1964

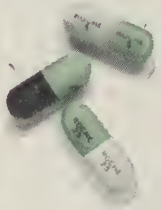
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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularit nausea and constipation, extrapyramidal symptoms, increased and decreased libid all infrequent and generally controlled wit dosage reduction; changes in EEG patter (low-voltage fast activity) may appear dur and after treatment; blood dyscrasias (in- cluding agranulocytosis), jaundice and hepatic dysfunction have been reported o casionally, making periodic blood counts and liver-function tests advisable during protracted therapy.

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Vol. 17, No. 2
February, 1968

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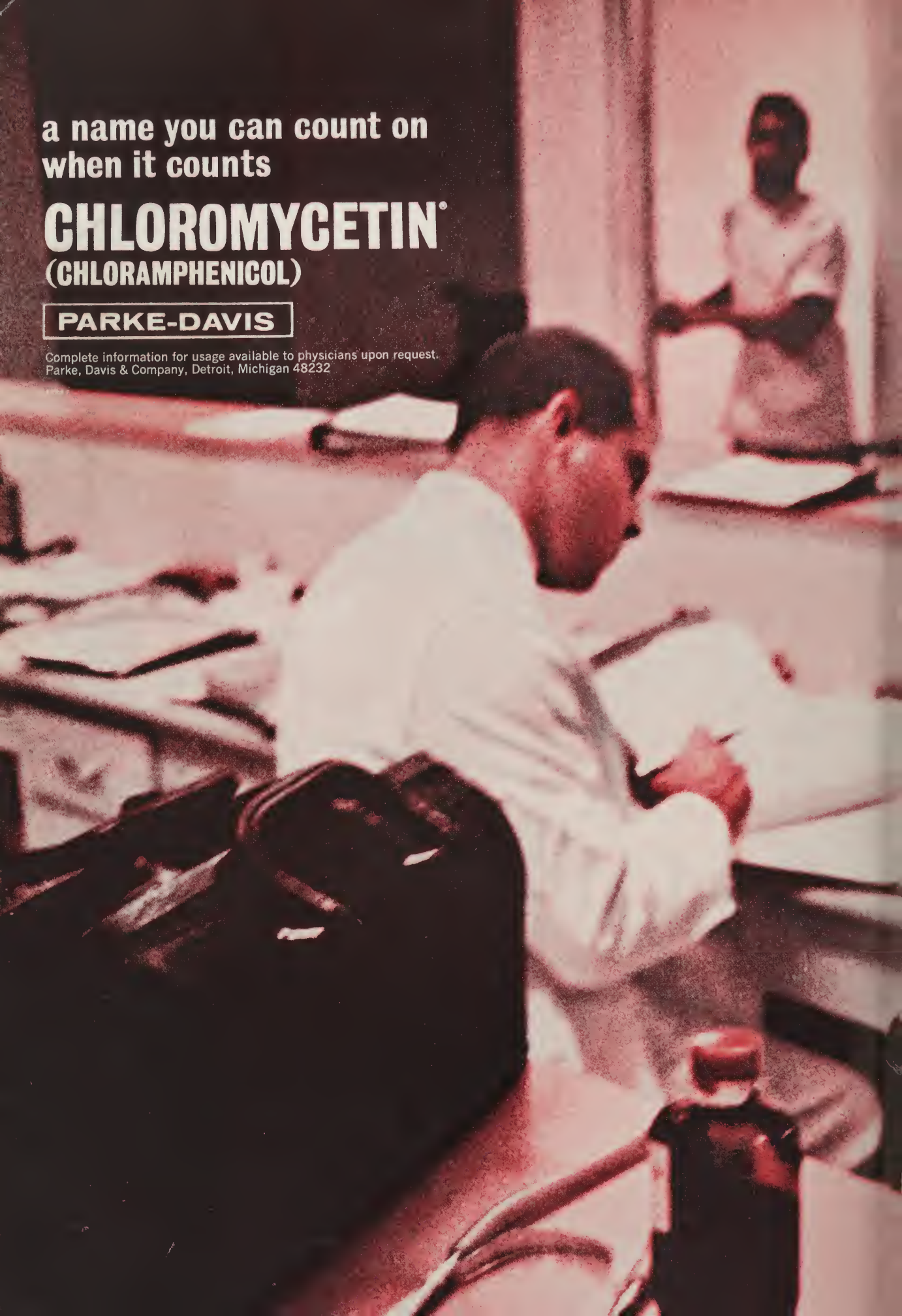
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JTC: LJY
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OFFICIAL PUBLICATION OF THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

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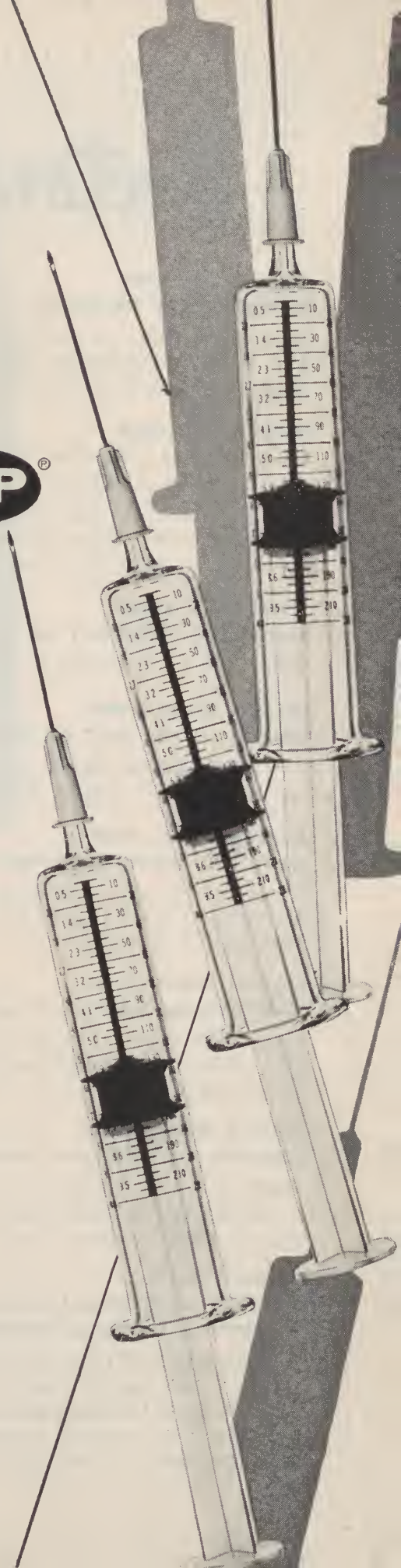

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Doctors take note...

MARCH 7-9, 1968
NEWARK CITY HOSPITAL

Postgraduate Course—Culdoscopy: Newark City Hospital, Newark, N.J. Chairman, James L. Breen, MD, FACOG. Registration information: Department of Gynecology and Obstetrics, Newark City Hospital, Newark, N. J. 07107.

MARCH 7-9, 1968
MOUNT SINAI HOSPITAL IN NEW YORK

Postgraduate Course—Obstetrics and Gynecology: Speaker: Ernest Page, MD, FACOG, Professor and Chairman of the Department of Obstetrics and Gynecology, University of California Medical School. Registration forms: Registrar, The Page and William Black Post-Graduate School of Medicine, 100th St. at 5th Ave., New York, N. Y. 10029.

MARCH 10, 1968
MARYLAND ACADEMY OF GENERAL PRACTICE

Board of Directors Meeting, 11 A.M.: Maryland Room, Holiday Inn Downtown, Baltimore, Md.

MARCH 11-13, 1968
AMERICAN COLLEGE OF SURGEONS

Three-Day Sectional Meeting: Williamsburg, Va. Contact: Mr. T. E. McGinnis, American College of Surgeons, 55 E. Erie St., Chicago, Ill. 60611 (For more detailed information, see page 161.)

MARCH 15-17, 1968
NATIONAL HEALTH COUNCIL

Forum on current standards, methods and practices: Statler-Hilton Hotel, Los Angeles, Calif. Contact: Arthur Jack Grimes, National Health Forum Coordinator, National Health Council, 1740 Broadway, New York, N. Y. 10019.

MARCH 18-20, 1968
HAHNEMANN MEDICAL COLLEGE AND HOSPITAL

Postgraduate Course—Psychodelic Drugs: Marriott Motor Hotel, Philadelphia, Pa. Director, Paul Jay Fink, MD. Contact: Sage Rosen, Assistant Director, Postgraduate Education, Hahnemann Medical College and Hospital, Dept. of Medicine, 230 N. Broad St., Philadelphia, Pa. 19102.

MARCH 22-23, 1968
COUNCIL ON MEDICAL SERVICE, AMERICAN MEDICAL ASSOCIATION

Socio-Economics of Health Care: Palmer House, Chicago, Ill. Contact: Division of Socio-Economic Activities, Dept. of Health Care Services, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610. (Requests for hotel reservation cards must be received before February 23, 1968.)

MARCH 25, 1968
SECTION OF INTERNAL MEDICINE OF BALTIMORE CITY MEDICAL SOCIETY-MARYLAND SOCIETY OF INTERNAL MEDICINE

Joint Meeting, 8:15 P.M.: Osler Hall, Medical-Chirurgical Faculty of Maryland, 1211 Cathedral St., Baltimore, Md. Speaker: David E. Rogers, MD., Professor and Chairman of the Department of Medicine, Vanderbilt University Medical School and Hospital, and newly appointed Dean of the Medical Faculty and vice president (medicine) of The Johns Hopkins University School of Medicine and Medical Director of The Johns Hopkins Hospital.

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Precautions—Overgrowth of nonsusceptible organisms may occure. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth— dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm. given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Acute gonococcal anterior urethritis in males has been treated effectively with a single dose of 600-900 mg. of DECLOMYCIN Demethylchlortetracycline. Individuals unable to tolerate large single doses due to gastrointestinal side effects may be treated with 150 mg. every 6 hours for a minimum of 4 doses or 300 mg. every 12 hours for a minimum of 2 doses. Females should be treated with a dosage of 150 mg. every 6 hours or 300 mg. every 12 hours until a cure is effected.

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Vol. 17, No. 2
February, 1968

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THIRD FRANKLIN SQUARE HOSPITAL SEMINAR

Sunday, March 3, 1968

Topic: "The Role of the Emergency Department in the Community"

Speaker: Robert H. Kennedy, MD
Director, Field Program Committee on Trauma,
American College of Surgeons

Registration: 8:30 A.M.

Breakfast: 9-9:45 A.M.

Principal Address: 10:00 A.M. to Noon

Cost: $3.50

Dr. Kennedy is nationally recognized for his efforts to impove the quality of care in Emergency Departments. In many hospitals, the emergency department is the weakest area of hospital care. The intrinsic reasons are innumerable. Adding the extrinsic problem of the "outpatient explosion" further compounds this dilemma.

In Maryland alone, in 1965, there were 1,507,057 visits to organized clinics and emergency rooms. Outpatient visits are increasing at almost double the rate of inpatient days. Nationwide outpatient visits are running over nine million per month.

These trends are changing the complexion of medical practice in all parameters, from the general practitioner to the hospital-based physician, to say nothing of the changes required in hospital construction and administration.

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Editorial and Business Office: 1211 Cathedral Street, Baltimore, Maryland 21201. 539-0872 (Area Code 301)

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Wednesday, Thursday, Friday
April 17, 18, 19, 1968
IN BALTIMORE

Three days of excellent **scientific sessions** have been planned for the Annual Meeting in Baltimore by the **Committee on Program and Arrangements,** of which **Thaddeus E. Prout, MD** is the Chairman. These will provide an opportunity for postgraduate education for house officers and students, as well as practicing physicians in all fields of medicine.

HOUSE OF DELEGATES MEETING

Baltimore

Wednesday, April 17, 9:30 A.M., at the Alcazar and Friday, April 19, 2:00 P.M. at the Faculty Building.

QUIZ THE EXPERTS LUNCHEON

Wednesday, April 17

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Wednesday, Thursday, Friday
April 17, 18, 19

The Alcazar, Baltimore

(See next page for list of technical exhibitors.)

MEDICAL AND CHIRURGICAL FACULTY

Sunday, April 21 to Sunday, April 28, 1968

CARIBBEAN CRUISE CONVENTION

Sunday, April 21	Sail from Baltimore at approximately 4:00 P.M.
Monday, April 22 and Tuesday, April 23	**Scientific sessions** and **films aboard ship,** with time for fun - sunning, swimming, entertainment, dancing, movies, and excellent food
Wednesday, April 24	**Scientific session** and **film** in A.M. Arrive San Juan about 1:00 P.M.
Thursday, April 25	Arrive in St. Thomas about 9:00 A.M.
Friday, April 26 and Saturday, April 27	**Scientific sessions** and **films aboard ship,** with time for fun as noted above
Sunday, April 28	Arrive in Baltimore about 2:00 P.M.

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TECHNICAL EXHIBITS—A WORTHY FEATURE OF THE EDUCATIONAL PROGRAM
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at the Alcazar, Baltimore
April 17, 18, 19, 1968

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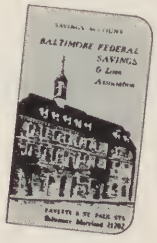
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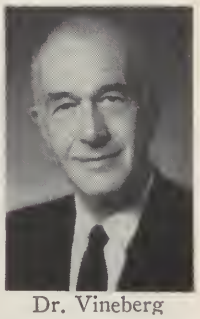
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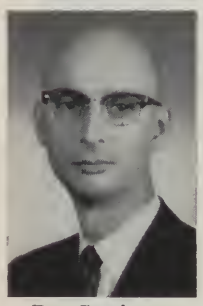


TO SPEAK AT THE ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY APRIL 17-28, 1968

In addition to speakers noted in the January issue of THE JOURNAL, the following eminent men of medicine are among those who will present papers during the three days in Baltimore at the Alcazar:


Dr. Vineberg

ARTHUR VINEBERG, MD, will give a paper on the surgery for coronary artery disease, which he has developed and is now widely used. This will be given on Thursday afternoon, April 18. He is Associate Professor of Surgery at McGill University and Senior Cardiac Surgeon at the Royal Victoria Hospital in Montreal. Dr. Vineberg received his MD, CM and MSc (biochemistry) from McGill University. He was a surgical houseman at the Bellevue Hospital, Presbyterian Division, New York. Dr. Vineberg in 1937 organized, and was chairman of, the first summer school in tuberculosis in Canada, which was modeled as closely as possible after the Trudeau School at Saranac Lake. In 1942 he was winner of the Casgrain-Charbonneau Prize, which is awarded to the McGill graduate who is under forty years of age and who, in the opinion of the Committee, has made the best contribution from date of graduation to the time of his 40th birthday. Dr. Vineberg has specialist certification by the Quebec College of Surgeons, Thoracic and General Surgery, and is a founder member of the American Board of Thoracic Surgery. Among the numerous memberships in scientific societies, he is a fellow of the American College of Chest Physicians, American College of Surgeons, American Heart Association, Montreal Heart and Canadian Heart Association, Canadian Medical Association, Montreal Clinical Society and Montreal Chirurgical Society.


Dr. Gastineau

CARE OF THE UNSTABLE DIABETIC will be the title of a paper to be given on Friday morning, April 19, by **CLIFFORD F. GASTINEAU, MD,** who is Associate Professor in Medicine at the Mayo Foundation Graduate School, University of Minnesota. Dr. Gastineau received his MD from the University of Oklahoma, and was a fellow in the Mayo Foundation for six years. He obtained a PhD in Medicine from the University of Minnesota in 1950 and since that time has been a member of the Staff of the Mayo Clinic. Dr. Gastineau is editor of the *Forecast,* a lay publication for diabetes sponsored by the American Diabetes Association, and is on the Editorial Board of the Journal *Diabetes.*


Dr. Hellman

LOUIS M. HELLMAN, MD, Professor and Chairman, Department of Obstetrics and Gynecology, State University of New York, Downstate Medical Center, will speak on the **SAFETY OF ORAL CONTRACEPTIVES.** This presentation also has been scheduled for Friday morning. Dr. Hellman received his MD degree from The Johns Hopkins University School of Medicine and served an internship in surgery and a residency in pathology at the New York Hospital, followed by an internship in obstetrics and a residency in gynecology at The Johns Hopkins Hospital. He was co-director of the obstetrical anesthesia program at The Johns Hopkins Hospital between 1946 and 1950. Dr. Hellman's current national positions include that of Chairman of the Executive Committee and Vice Chairman of the Board of Directors of the National Committee on Maternal Health, Associate Examiner for the American Board of Obstetrics and Gynecology, a member of the Research Advisory Board of the National Association for Retarded Children, a member of the Health Research Council of New York City, Chairman of the Advisory Committee on Obstetrics and Gynecology of the Federal Food and Drug Administration, a member of the Joint Commission on Mental Health of Children, and Chairman of the Board of Directors of the Association for the Study of Abortion. Dr. Hellman is a member of numerous scientific societies, has several editorial positions, has given many lectureships throughout the United States and abroad, and is the author of over one-hundred publications.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. A brief precautionary statement follows.

Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction, or bladder neck obstruction.

Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.

Usage in Pregnancy: Use cautiously, especially in the first trimester. *Note:* The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.

Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible side effects of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported but no causal relationship has been established.



a stuffy nose is no laughing matter

Ornade® Trademark

Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

Spansule® Capsules

brand of sustained release capsules

each one can give him all-day or all-night relief of nasal congestion

SK&F Smith Kline & French Laboratories

The Medical and Chirurgical Faculty
The State Department of Mental Hygiene and
The Baltimore Area Council on Alcoholism
will present
A One-Day Seminar for Physicians
on
TREATMENT OF ALCOHOLICS

Date: THURSDAY, MARCH 7, 1968

Place: MOUNT WILSON STATE HOSPITAL

Lewis P. Gundry, MD, Presiding
Chairman, Subcommittee on Alcoholism, Medical and Chirurgical Faculty

9:30 A.M.—REGISTRATION

10:00 A.M.—WELCOME TO MOUNT WILSON—William Newcomer, MD, Superintendent

10:15 A.M.—DIAGNOSIS AND OFFICE TREATMENT OF ALCOHOLISM—Marvin A. Block, MD

Presentation and open discussion

Dr. Block, a practicing physician in Buffalo, New York, was chairman of the AMA Committee on Alcoholism from 1954-64, and is currently a member of the AMA Committee on Alcoholism and Drug Dependence.

11:30 A.M.—INTERVIEW WITH AN ALCOHOLIC PATIENT—Maxwell N. Weisman, MD

Demonstration and open discussion

Dr. Weisman is Director of Alcoholism Programs for the Maryland State Department of Mental Hygiene, a member of the Faculty of Rutgers Summer School of Alcohol Studies, a consultant to the National Council on Alcoholism, Inc., and a member of the Task Force on Alcohol Problems of the National Council of Churches.

12:30 P.M.—LUNCHEON (Mt. Wilson Cafeteria)

1:30 P.M.—INTERDISCIPLINARY TREATMENT OF THE ALCOHOLIC PATIENT—Ruth Fox, MD

Presentation and open discussion

Dr. Fox is a practicing psychiatrist in New York City and Medical Director of the National Council on Alcoholism, Inc. She is co-author of *Alcoholism, Its Scope, Cause and Treatment,* and edited *Alcoholism—Behavioral Research Therapeutic Approaches.*

2:45 P.M.—CLOSING REMARKS AND GENERAL DISCUSSION

Application has been made for American Academy of General Practice Credits.

REGISTRATION FORM—SEMINAR ON TREATMENT OF ALCOHOLICS

Registration fee including lunch—$1.50 (All tickets will be held at registration desk.)

Enclosed is my check in the amount of ..... made payable to the MEDICAL AND CHIRURGICAL FACULTY for ..... (number) reservations for the Seminar on the Treatment of Alcoholics, Thursday, March 7, 1968 at Mount Wilson State Hospital.

Name .....Address .....

Medical Specialty .....

Mail to: Seminar on the Treatment of Alcoholics, Medical and Chirurgical Faculty, 1211 Cathedral Street, Baltimore, Maryland 21201

DEPRESSION



NORPRAMIN®

(desipramine hydrochloride)

ANTIDEPRESSANT FOR RAPID IMPROVEMENT

At the recommended dosage level —initially, 150 mg. per day— gratifying remission of the signs and symptoms of depression typically begins in 2-5 days. Its specificity for depression, rapidity of action and usually mild side effects are significant reasons for prescribing NORPRAMIN (desipramine hydrochloride) in depression of any type . . . any degree of severity.

A few patients, sensitive to central nervous system stimulants may become restless as depression is lifted—in such cases dosage may be reduced or a tranquilizer added.

INDICATIONS: In depression of any kind—neurotic and psychotic.

CONTRAINDICATIONS: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease, epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor.

RELATIVE CONTRAINDICATIONS: (1) Patients with a history of paroxysmal tachycardia. (2) Patients receiving concomitant therapy with thyroid, anticholinergics or sympathomimetics may experience potentiation of effects of these drugs. (3) Safety in pregnancy has not been established. (4) Perform liver function studies in patients suspect of having hepatic disease.

PRECAUTIONS: (1) Outpatient use of desipramine hydrochloride should not be substituted for hospitalization when risk of suicide or homicide is considered grave. Suicidal ingestion of large doses may be fatal. (2) If serious adverse effects occur, reduce dosage or alter treatment. (3) In patients with manic-depressive illness a hypomanic state may be induced. (4) Discontinue drug as soon as possible prior to elective surgery.

ADVERSE EFFECTS: The following side effects have been encountered: dry mouth, constipation, dizziness, palpitation, delayed urination, agitation and stimulation ("jumpiness," "nervousness," "anxiety," "insomnia"), bad taste, sensory illusion, tinnitus, sweating, drowsiness, headache, hypotension (orthostatic), flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, *tremor*, allergy (general), altered liver function, ataxia and extrapyramidal signs, agranulocytosis.

Additional side effects more recently reported include: seizures, eosinophilia, confusional states with hallucinations, purpura, photosensitivity, galactorrhea, gynecomastia, and impotence. Side effects which could occur (analogy to related drugs) include weight gain, heartburn, anorexia, and hand and arm paresthesias.

DOSAGE: Optimal results are obtained at a dosage of 50 mg. t.i.d. (150 mg./day).

SUPPLIED: NORPRAMIN (desipramine hydrochloride) tablets of 25 mg.: bottles of 50, 500 and 1,000; and tablets of 50 mg. in bottles of 30, 250, and 1,000.

LAKESIDE

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VACCINES: A SUCCESS STORY

Basic research in virology and immunology is paying off handsomely for medicine through enhanced ability to produce effective vaccines.

Measles (rubeola) vaccine has proven so effective that some clinicians speak of using it to "eliminate" the disease from the United States. An anti-measles vaccination campaign is being conducted by the American Medical Association and U.S. Public Health Service, and its success can be measured by the fact that fewer measles cases were reported during the first half of 1967 than in any comparable period since measles record-keeping began in 1912. Live-virus measles vaccine is recommended by many authorities now, in preference to killed-virus types.

At least four new vaccines should reach important stages of development within the next few months.

Licensure of a mumps vaccine was expected before the end of the year, according to one of its developers, Maurice R. Hilleman, PhD, Merck Institute for Therapeutic Research. It has been given to approximately 6,500 persons in experimental clinical trials "with excellent serologic response and protective efficacy, and without untoward clinical effect," Dr. Hilleman reported.

A vaccine against German measles (rubella) may be generally available within two years, according to investigators at the National Institutes of Health. Clinical trials with an experimental vaccine have been underway more than two years, with more than 500 persons vaccinated.

University of Chicago investigators hope during the next year to immunize about 200 children with an experimental vaccine designed to prevent streptococcal infections of the type which often are responsible for rheumatic fever and certain kinds of kidney disease. About 40 adults and 25 infants have received the vaccine since its development last year. Twenty of the 25 infants responded with production of antibodies capable of destroying streptococcus, reported Eugene N. Fox, PhD, Albert Dorfman, MD, and associates.

A vaccine to prevent erythroblastosis fetalis (Rh disease) also may be licensed in 1968. The vaccine is an anti-Rh immune globulin which is given to an Rh-negative mother after the birth of her first Rh-positive infant. The globulin acts to prevent an immunological attack by the mother's body upon the fetus during a second pregnancy, presumably through a mechanism of antibody-induced immunosuppression.

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Tablets & Elixir
For Iron Deficiency Anemia
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Thursday . . . 9:30 A.M. to 8:30 P.M.

EXECUTIVE SECRETARY'S NEWSLETTER

February, 1968

REFERENCE COMMITTEE HEARING

Wednesday, March 13, at 8:00 p.m., at the Faculty Building is the present schedule for the Reference Committee meeting on Resolutions for the Annual Meeting.

STATE LEGISLATIVE ACTIVITY

Members are urged to watch for the several issues of The Assemblyman, the Faculty's Legislative Newsletter, mailed periodically during the annual session of the State Legislature.

Individual bills involving the profession are reported on, together with the Faculty's position on such a bill, if one is being taken.

Those physicians interested in specific proposals or bills should advise the Faculty office so they can be informed of public hearings or pertinent data involving such legislation.

ALCOHOLISM MANUAL

Copies of the "Manual on Alcoholism" are available to members through the Faculty office.

IMPORTANT INFORMATION

The Federal Government, in announcing the new $4.00 monthly rate for Medicare, Part B, has given the following data as to the distribution of the increase of $1.00:

20¢ to finance the program at the level of operation of the past, because of low estimates of the financing;

25¢ because of a higher utilization of benefits by subscribers, because the $50. deductible portion will exclude a smaller portion of medical expense as the utilization increases;

25¢ because of expected increase in the cost of physicians fees during the next five years;

23¢ to pay for increased benefits, such as full payment for diagnostic radiology and pathology;

7¢ to cover contingency purposes.

NEWS NOTES

A special MEDIC program is to be presented on Thursday, February 29, from 1 to 4 p.m., on the network. The subject is Comprehensive Seminar on Effects of Rubella epidemic of 1964.

NEWS NOTES (cont'd)

New officers of the Maryland Society of Pathologists include: Watson P. Kime, M.D., President; Harlan I. Firminger, M.D., Vice-President; W. Bradley King, Jr., M.D., Secretary-Treasurer; and Robert L. Cavenaugh, M.D., Edward L. Sherrer, M.D., John E. Adams, M.D., Councilors; Robert G. Lancaster, M.D., ASCP Councilor; and Lawrence F. Misanik, M.D., Alternate ASCP Councilor.

Mr. Walter B. Thomas has been named Executive Director of the Maryland Diabetes Association.

New Fellows of the American College of Anesthesiology include: Michael N. Ashman, M.D., and Rogelio M. Carrera, M.D., both of Baltimore.

NEW WORKMEN'S COMPENSATION FORMS

A new SF-2, Workmen's Compensation form is announced by the Workmen's Compensation Commission.

The main purpose of the new form is to rearrange the information and to provide additional space where needed.

Physicians should use up their current supply of SF-2, requesting the new form when their supply is exhausted.

A copy of the new form will be mailed with the next issue of The Assemblyman, so that physicians can become acquainted with it.

Physicians are reminded that an Early first report must be filed as well as Progress and Final reports. Cooperation of the profession is the foundation on which the State Rehabilitation program can be built.

PERSONALITIES

C. Edmund Rybczynski, M.D., has been certified a Diplomate of the American Board of Obstetrics and Gynecology.

John Sargent
Executive Secretary

FINANCIAL MANAGEMENT

DOCTOR

Your System Also Needs
Periodic Check-Ups . . .
Improved routines and
positive controls.

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"PM SYSTEM"
COMPLEMENTS
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OFFERS YOU
MAXIMUM CONTROL AND SAFETY
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NOT A CURE ALL—BUT
THE BEST AIDE KNOWN



NEW!

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POCKET SIZE DIAGNOSTIC SET

Lightweight . . . compact . . . economical . . . always at hand and ready to use. Using the newest principles of optics, for brilliant illumination and clear, unobstructed vision. Power from long-life alkaline batteries.

The OTOSCOPE

- **Latest Welch-Allyn fiber optics system**
- **Only 2¼ oz. in weight complete**
- **Uses Kleenspec disposable specula in 4mm. size**

The OPHTHALMOSCOPE

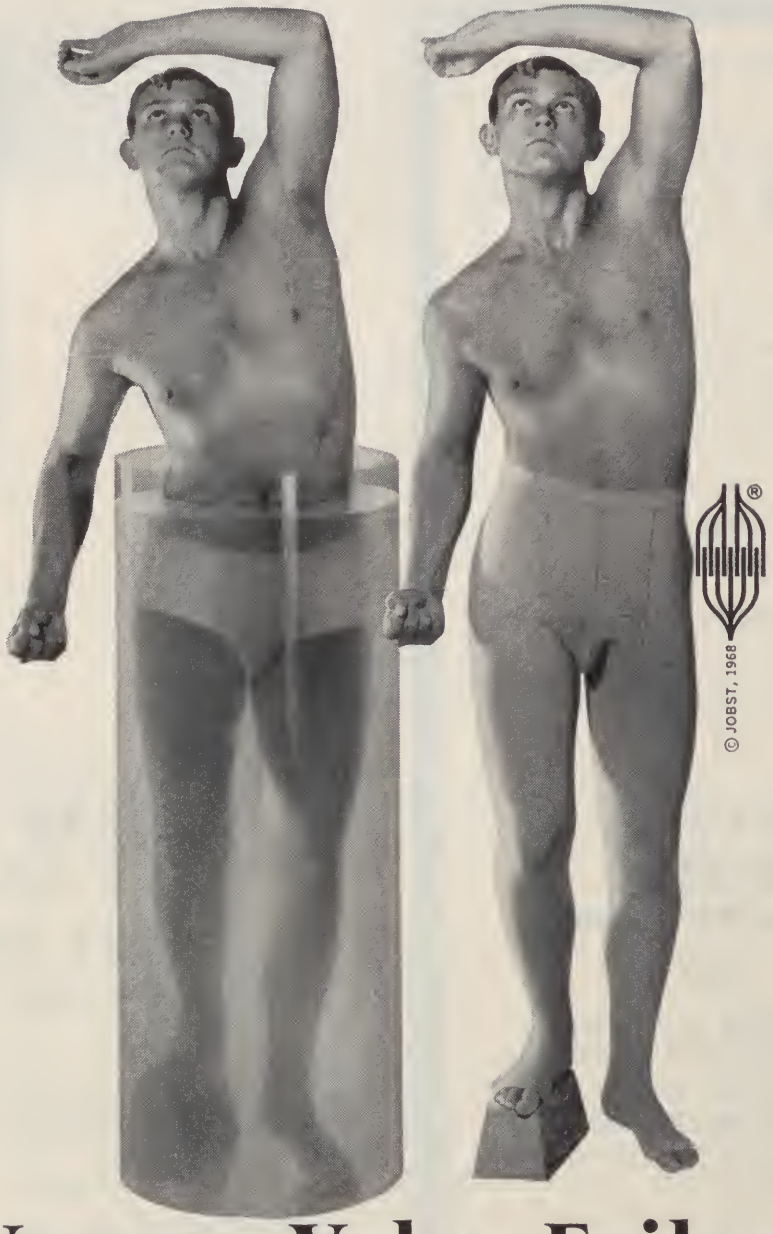
- **Newest Welch-Allyn mirror optical system**
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—can be treated by immersing the patient in a tank of water, because the hydrostatic pressure in the tank will closely duplicate his normal venous return pressure and thus give him immediate relief.

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THE MONTH IN WASHINGTON

President Johnson signed into law the social security legislation which included changes in medicare and medicaid advocated by the medical profession.

The legislation provides for a record high minimum 13% increase in cash benefits for 24 million Americans, starting in March. Beginning April 1, one dollar a month of the increase will be withheld from the checks of those participating in voluntary Plan B of medicare which covers part of physician fees and other medical services other than hospitalization.

The total premium for Plan B insurance is now $6 a month, half of which is paid by the federal government. Beginning April 1, the premium will be increased to $8, with the government paying $4 and the participant $4.

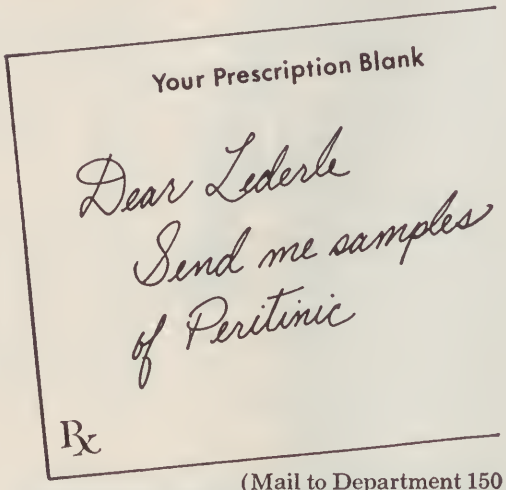
According to HEW, about 20 cents of the $1 increase was needed to cover costs which were originally underestimated. Another 25 cents would cover expected increase of use under the program. An anticipated 5% increase in physician fees would account for another 25 cents.

The social security taxable base also was increased, effective January 1, from $6,600 to $7,800. The tax rate for this year will remain the same as under the old law, 4.4% on both the employee and employer and 6.4% on the self-employed. Tax rate increases are set for subsequent years through 1987.



Here's what you do to get samples of the

anticostive* hematinic



(Mail to Department 150
Lederle Laboratories,
Pearl River, New York 10965)

* anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic?)

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Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

Lederle

489-7—6063

Medicare Changes

- Payment of physician fees is authorized either to the patient on the basis of an itemized bill, either unpaid or receipted as paid, or to the physician under the assignment method.
- Payment is authorized for full reasonable charges for radiological or services furnished by physicians to hospital inpatients.
- Hospital outpatient diagnostic services are transferred from the hospital insurance program (Plan A) to the supplementary medical insurance program (Plan B). The change was designed to simplify the procedure for paying benefits for hospital outpatients.
- The requirement of physician certification of the medical necessity for admission to general hospitals and for hospital outpatient services was eliminated.
- Medicare beneficiaries are given a lifetime reserve of 60 additional days of hospital care after the 90 days covered in a spell of illness. The beneficiary must pay the first $20 per day for the additional hospitalization.
- The Secretary of HEW was directed to study and report to Congress by January 1, 1969, the effects of covering drugs under medicare and of establishing quality and cost standards for drugs provided under social security health programs.
- Services of podiatrists are authorized under medicare to the extent that a state's law permits, but routine foot care is not covered.
- Outpatient services furnished by physical therapists are authorized within certain limitations.
- The Secretary of HEW was directed to study and make recommendations of adding services of chiropractic and optometrists to Plan B.
- Payment is authorized under Plan B for diagnostic X rays taken in a patient's home or a nursing home.

Medicaid Changes

- States are limited in setting eligibility income levels for federal matching purposes.
- States are given until January 1, 1970, to buy-in medicare Plan B insurance for aged medicaid beneficiaries.

• States are authorized to make direct payments to medicaid beneficiaries for physicians' and dentists' services if the beneficiary is not receiving cash assistance.

• States are permitted to select either the five basic health services, or 7 out of the 14 authorized, for the medically indigent. The basic 5 must be provided for those receiving welfare cash benefits. The basic 5 are: inpatient hospital services, outpatient hospital services, other laboratory and X-ray services, skilled nursing home services and physicians' services.

• States must license administrators of nursing homes and set minimum nursing home standards if these institutions are to be eligible to participate in the medicaid program.

• States must establish methods and procedures to safeguard against unnecessary utilization of health care services and to assure that payments for such services and drugs do not exceed reasonable charges.

Under the program for Aid to Families with Dependent Children (AFDC), states now must offer birth control services to appropriate beneficiaries with acceptance on a voluntary basis. Authorizations for federal financial aid for maternal and child health programs are increased. Services of optometrists are added to child health programs.

* * * * *

James L. Goddard, MD, commissioner of the Food and Drug Administration, estimated that about 300 drugs, marketed under 1,600 brand names, will be forced off the market because of ineffectiveness for treatment of medical conditions.

An evaluation of some 3,000 drugs placed on the market from 1938 to 1962 was started in June, 1966. It is being conducted by 29 panels of 200 medical and pharmaceutical specialists under the direction of the National Academy of Sciences–National Research Council. With the first panel reporting in January, the last report is due in mid-1969.

The FDA assigned the evaluation to the academy following passage of the Kefauver Drug Law in 1962. The law's main thrust was to give FDA power to pass on the efficacy as well as the safety of drugs marketed after 1962, but a provision authorized the government to review drugs already on the market.

The federal government has licensed a live, attenuated mumps virus vaccine especially recommended for adolescent and male adults who can become sterile from the relatively innocuous childhood disease.

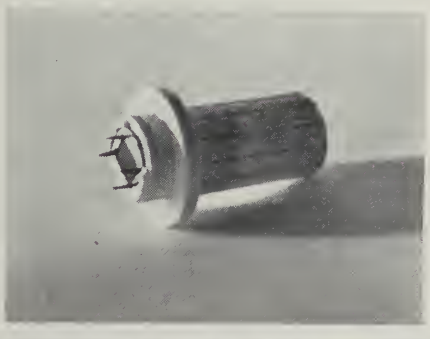
The vaccine, developed over a five-year period by the Merck, Sharp and Dohme Research Laboratories, was not recommended for routine use in infants and young children pending development of more information in the duration of the immunity it provides.

William H. Stewart, MD, U. S. Surgeon General, said excellent protection against naturally occurring mumps has been observed for the first year after the single-infection live vaccine.

"But limited data on natural exposure during the second year indicate continuing protection although additional observation will be required to determine the duration of immunity protection," he said.

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Make tuberculin testing routine with every physical examination.



TUBERCULIN, TINE TEST
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Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

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It is not a simple matter. And yet, with professional legal counsel and the assistance of our Trust Department, it's not "horribly complicated" either.

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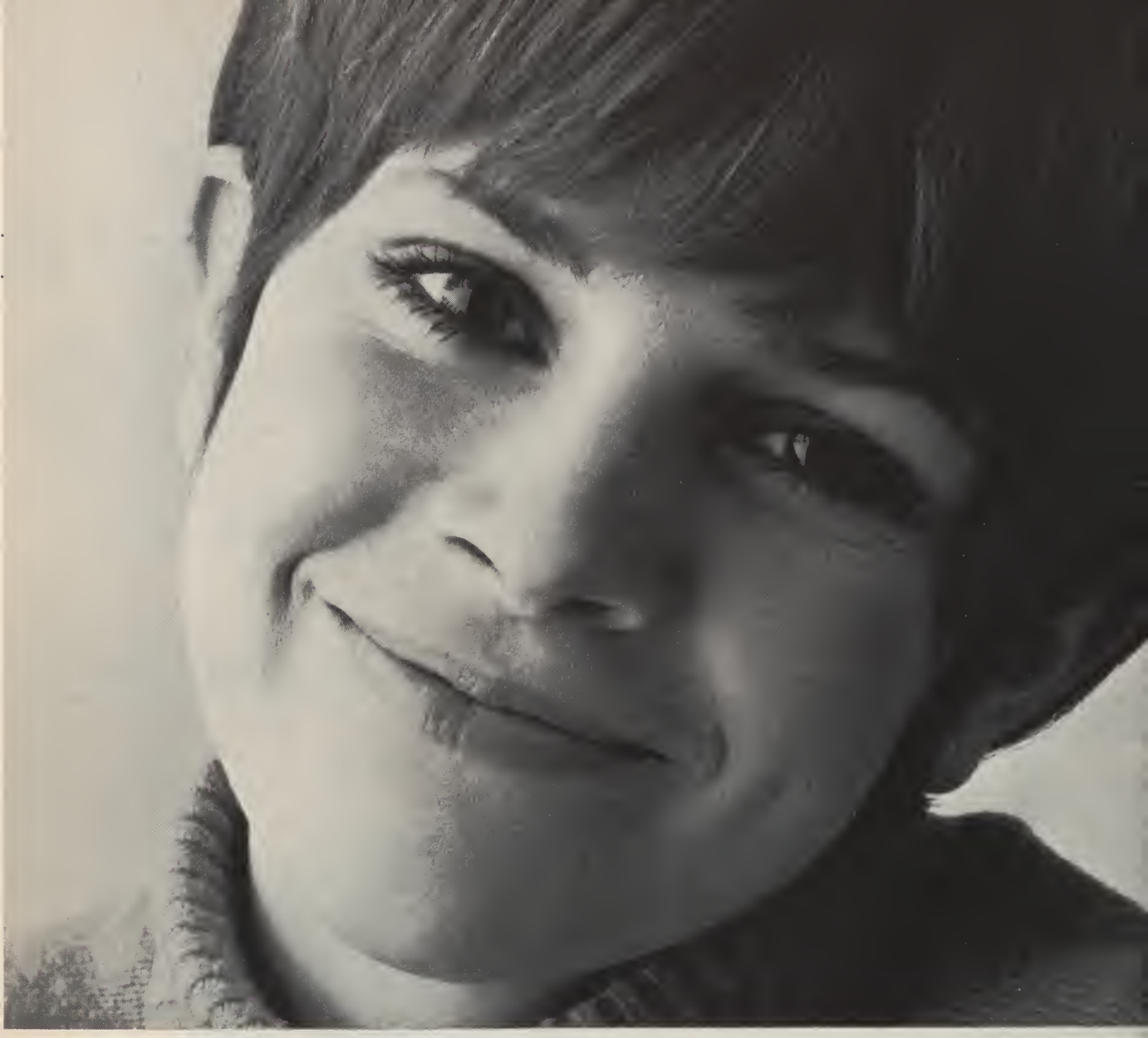


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No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

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ORAL **PEN•VEE® K**

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If hypothyroidism leaves your patient feeling like this...

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(SODIUM LEVOTHYROXINE, ARMOUR) TABLETS

Synthetic Thyroid Replacement Therapy



Letter® provides all the advantages of the synthetically pure chemical sodium levothyroxine. Dosage is precise and potency is consistently uniform.

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Letter® is micronized to provide maximum opportunity for full absorption and clinical response.

In addition Letter® is distinctively color coded with an identifying number stamped on each tablet to provide accurate dosage control.

Indications: Hypothyroid conditions. **Contraindications:** Thyrotoxicosis, acute myocardial infarctions unless associated with hypothyroidism. In hypothyroidism with hypoadrenalism coadministration of corticoids with LETTER® is recommended. **Precautions and Side Effects:** Excessive dosage may result in diarrhea, cramps, palpitation, nervousness, rapid pulse, sweating. If symptoms appear, discontinue medication for several days, then reinstitute at a lower level. Since myxedema patients with heart disease may suffer seriously from abrupt increases in dosage, caution should be exercised in adjusting dosage. **Dosage:** Generally, the initial adult dosage is 0.1 mg. daily. This may be increased in small increments every one to three weeks until proper metabolic balance is achieved. **Available:** Bottles of 100 tablets, in six potencies: 0.025 mg. (violet), 0.05 mg. (peach), 0.1 mg. (pink), 0.2 mg. (green), 0.3 mg. (yellow), and 0.5 mg. (white).

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The full ¼ grain of phenobarb in the formula

takes the nervous edge off the pain
...helps bring out the best in codeine

Phenaphen® with Codeine

the only leading compound analgesic that calms instead of caffeinates

Each capsule contains:

Phenobarbital (¼ gr.) ..... 16.2 mg.
(Warning: may be habit forming)
Aspirin (2½ gr.) .....162.0 mg.
Phenacetin (3 gr.) .....194.0 mg.
Hyoscyamine sulfate.....0.031 mg.
Codeine phosphate.....¼ gr. (No. 2),
½ gr. (No. 3), 1 gr. (No. 4)
(Warning: may be habit forming)

Contraindications: Hypersensitivity to any ingredient.

Precautions: As with all phenacetin-containing products, avoid excessive or prolonged use.

Side Effects: Side effects are uncommon—nausea, constipation and drowsiness have been reported.

A-H-ROBINS

A. H. ROBINS CO., INC., Richmond, Va. 23220

For your impatient cold patients

Two sprays from NTZ Nasal Spray—and nasal congestion, rhinorrhea, sneezing are reduced for *immediate* comfort for patients with colds.

NTZ is more than a simple vasoconstrictor. It contains:

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction on contact.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.

NTZ is well tolerated. Used in a cold it may help prevent sinusitis by opening sinus ostia and permitting drainage. It may also be used in sinusitis to help establish drainage.

The spray is best used twice, the second a few minutes after the first, repeated every three or four hours as needed. NTZ is for temporary relief of nasal symptoms, and overdosage should be avoided.

Supplied: NTZ Nasal Spray, plastic squeeze bottles of 20 ml.; NTZ Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

Winthrop

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a puzzle of antacid complaints



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Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

References: 1. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966.
2. Danhof, I. E., Personal communication.

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...consolidates fluid stools with pectin
...adsorbs irritants with kaolin,
and protects intestinal mucosa

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Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) ..... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
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(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.
Usual Children's Dose: One or two teaspoonfuls three times daily.

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Book Reviews

NEUROLOGY OF THE VISUAL SYSTEM, by David G. Cogan, MD, Charles C. Thomas, Springfield, Ill.

Written as a companion to *Neurology of the Ocular Muscles,* this volume presents clinical aspects of the ocular sensory system. The clinical syndromes and their anatomophysiologic explanations are presented as briefly as is compatible with a clear exposition of their manifestations. The text follows an anatomic order. The viewpoint is primarily the author's, with abundant references to both support and refute his position.

PERSPECTIVES IN EXPERIMENTAL GERONTOLOGY, Nathan W. Shock, PhD; Charles C. Thomas, Springfield, Ill.

The goal of this book is to present an overview of ideas in the field of experimental gerontology, with emphasis on ideas and experiments. It represents, therefore, more a collection of essays than a detailed summary of all the factual data on specific problem areas.

Well organized throughout, it is not, however, by any means as complete as it might be. Space limitations required the "leaving out" of certain areas. Nonetheless, it is well worth adding to your library.

MENDELIAN INHERITANCE IN MAN, Victor A. McKusick; The Johns Hopkins Press, Baltimore, Md.

This publication is primarily a catalogue of the autosomal dominant, autosomal recessive and X-linked phenotypes. For the first time it utilizes the computer system for assemblying and the "print-out" from such system for the publication of this book. As a reference book it is an excellent addition to the medical library.

CLINICAL MANAGEMENT OF BEHAVIOR DISORDERS IN CHILDREN, Harry Bakwin, MD, and Ruth Morris Bakwin, MD; W. B. Saunders Company, Philadelphia, Pa.

This volume is a distillation from a large amount of literature and from the long and careful experience of the authors of those data that are most helpful in understanding and treating behavior problems in children. This is the third edition of this publication and it is comprehensive, practical and full of common sense. The gratitude of all pediatricians, child psychiatrists and parents should be rendered to them for such a clear and concise job of medical writing.

THE THEORY AND PRACTICE OF PSYCHIATRY, Fredrick C. Redlich, MD, and Daniel X. Freedman, MD; Basic Books, Inc., New York.

This thoroughly modern text is firmly rooted in history. No area of psychiatry is allowed to go by default, yet no single attitude is allowed to dominate. It is balanced, accurate and well-documented. It is a source book for case-centered observation, for clinical debate and for academic discourse.

THE BIOSOCIAL BASIS OF MENTAL RETARDATION, Sonia F. Osler, PhD and Robert E. Cooke, MD; The Johns Hopkins Press, Baltimore, Md.

This collection of various lectures dealing with mental retardation was prepared because of the heavy demand for such information. It is a direct result of a seminar course at the Johns Hopkins University School of Medicine established in 1960. It is an attempt to bring to students of medicine the most recent scientific developments in a field of great national concern. The publishers and authors have done well.

APPRAISAL OF CURRENT CONCEPTS IN ANESTHESIOLOGY, Vol. 3, Edited by John Adriani, MD, Professor of Surgery, Tulane University School of Medicine, New Orleans, Louisiana. C. V. Mosby Co., St. Louis, Mo.

This is the third edition of a collection of reviews prepared by the staff and residents in the Department of Anesthesiology at Charity Hospital and edited by Dr. Adriani. It is slightly larger than the second volume which was published in 1964, but very similar in style and format.

The aim of the book is to bridge the time gap between the current literature and its incorporation into future textbooks. In all, 50 different topics are covered. These reviews are primarily written for the practicing anesthesiologist and vary from subjects of clinical interest, i.e., adverse drug reactions, the use of drugs for cardiorespiratory resuscitation, hepatotoxicity of preoperative agents and the distribution and fate of volatile anesthetics, to equally valuable topics in fields allied to anesthesia, i.e., electrolyte disturbances in banked blood, the limits of radiation for hospital personnel, and the use of antineoplastic drugs during anesthesia. For those who need more detail or who desire to read further, there are ample references at the end of each review.

Dr. Adriani has concluded this edition with a comprehensive list of subject matter that he and other program directors feel should be taught to current residents in anesthesia. This is a dull reading in one sense, but it is also stimulating in that it encourages the reader to take an inventory of just what his own efforts have achieved in keeping up with today's concepts in anesthesia.

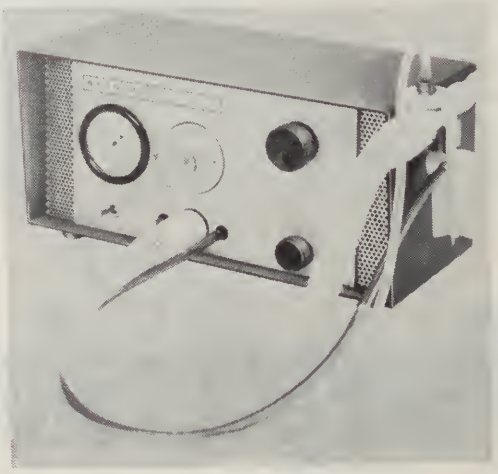
The book's handy size and brief reviews lends itself to the busy clinician who wishes to utilize short breaks in his schedule.

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THE NEUROSES: BY HENRY P. LAUGHLIN, MD

This volume, the successor to *The Neuroses in Clinical Practice* which was published in 1956, is an encyclopedic reference work covering all of the neuroses and character disorders usually encountered in clinical practice. The fact that it was produced by a single author but covers a wide field allows an integration and inter-relatedness missing in many comprehensive volumes by multiple authors.

Dr. Laughlin's theory of the etiology of the neuroses is psychoanalytically oriented and leans heavily on the concept that anxiety and its defensive reduction are central issues in all of the neuroses. His first chapter describes the many aspects of anxiety in a comprehensive way. The theme of conflict → anxiety → repression → symptoms initiated in this chapter is carried throughout the book with variations on the theme comprising descriptions of the various diagnostic categories of neuroses. "The underlying presence of intrapsychic conflict with the resulting tension, attempted defenses, and sought after resolution and its disguised outward expression is to be recognized today as the central dynamic concept in the origin of the neurotic and the functional psychotic emotional illness."

The second chapter also merits special comment. This chapter is devoted to an intense exploration of the concept of primary and secondary gain of emotional illnesses. Epigain (unconscious primary gain) and endogain (unconscious secondary gain) are differentiated from the more conscious secondary gain of the illness. These concepts, always mentioned as an integral part of emotional illness, are rarely elaborated as clearly as in this chapter.

For the most part the remainder of the book is devoted to descriptions of various neurotic illnesses, their psychodynamics, and treatment. In general, the diagnostic classification follows the currently used terminology with a few notable exceptions. The hypochrondrical reactions are described separately under the newly coined heading hygeiaphrontic (hygia meaning health, phrontis meaning "anxious concern about") reactions. The fatigue reactions are described separately from the depressive reactions because of their medical importance and some differences from the typical depressive reaction. In his chapter on Soterial Reactions Laughlin emphasizes a common phenomenon by defining and naming it. It would perhaps be more easily, but less aesthically, recognizable as the "Linus blanket" syndrome. Soterial ("a security of guarantee or safety") objects are extremely common but rarely a presenting complaint. There are also chapters on neuroses following trauma and military reactions.

The Neuroses is written in a simple, direct, almost conversational or lectorial form which makes it easily readable. This form does, however, encourage repetition which is somewhat distracting in such a comprehensive volume. Although possibly useful to the student using this as a textbook, this reviewer found the author's promulgation of "tenets," "concepts" and "principles" difficult to integrate and apply in a useful and meaningful way. The book is well indexed and has an extensive outline of chapter contents at the beginning of each chapter plus references and review questions at the end of each chapter. Included as appendices are an outline classification of mental illness and a glossary of psychiatric terms and concepts. Descriptions of concepts and illnesses are well illustrated with almost 200 case histories and there are 48 tables summarizing various aspects of the material presented.

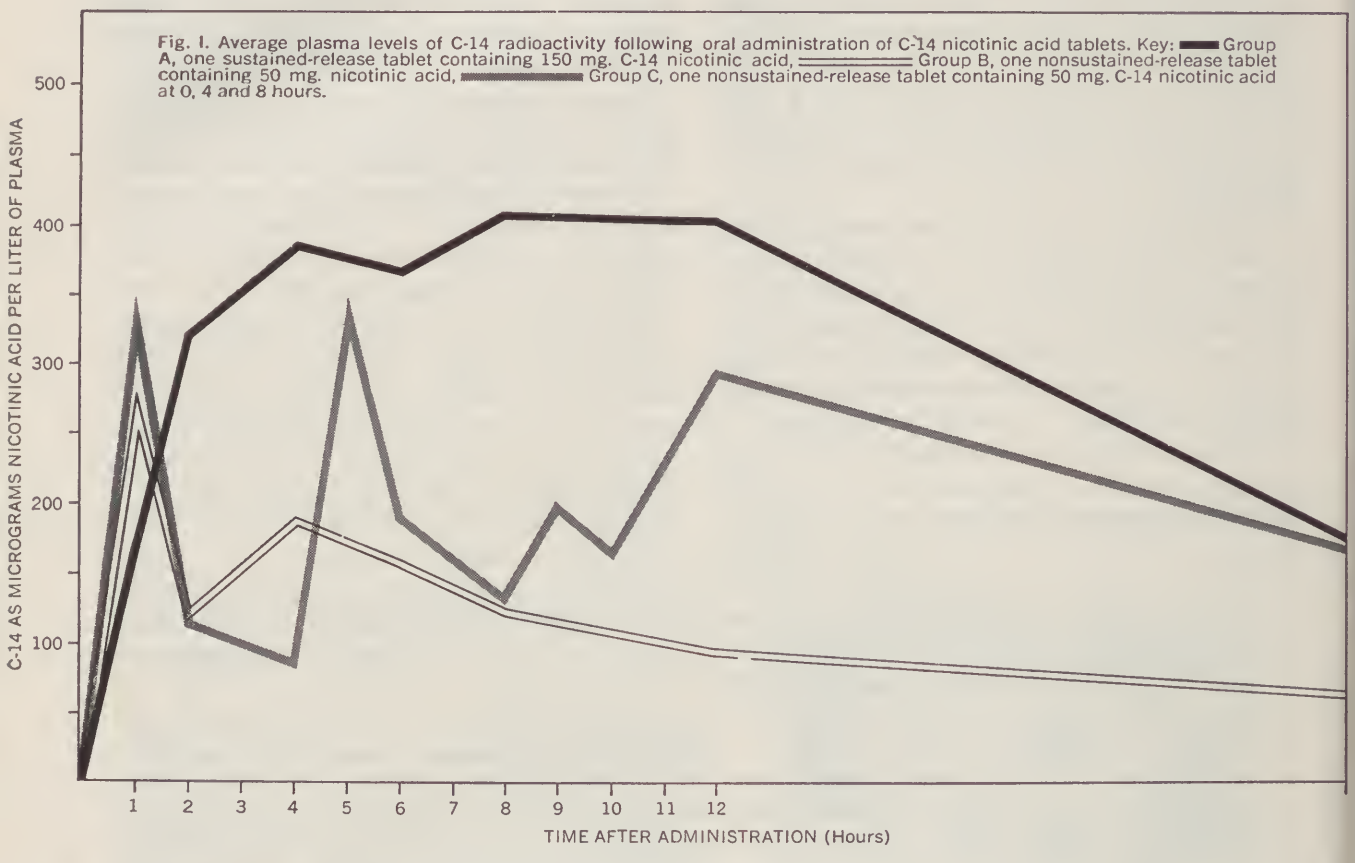
The book is highly recommended to medical students and residents in psychiatry as a basic textbook on the neuroses. It should also be very useful to the practicing physician (whether or not he specializes in psychiatry) and the teacher of psychiatry as a reference work.

THURMAN MOTT, JR., MD
Frederick Medical Center, Frederick, Md.

Ed. Note: *The Neuroses*, Henry P. Laughlin, MD; New York, Appleton-Century Crofts, 1967.

Dr. Laughlin is a past president of the American College of Psychiatrists; Associate Clinical Professor of Psychiatry, George Washington University School of Medicine, Washington, D.C.: Head, Division of Psychiatry, Suburban Hospital, Bethesda, Maryland.

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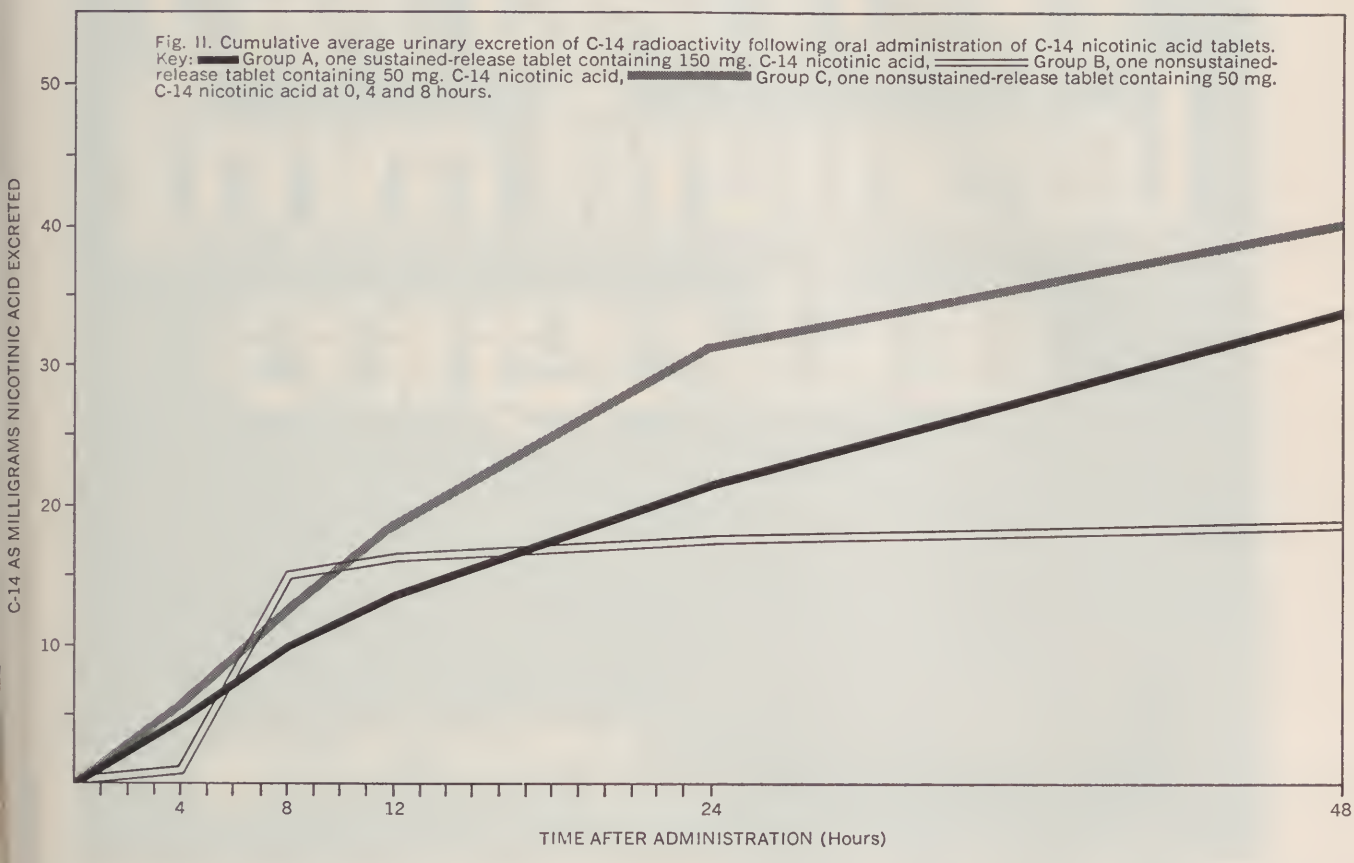
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References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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THE MULTIPLE ROAD

An experimental method of treating cancer by selectively starving tumor cells of essential amino acids has prolonged the lives of a number of patients, two University of Chicago cancer researchers reported.

Albert B. Lorincz, MD, and Robert E. Kuttner, PhD, described their studies at the 116th Annual Convention of the American Medical Association.

Biochemical assays of tumor cells have shown that every tumor has individual and distinctive amino acid requirements, Drs. Lorincz and Kuttner said.

Clinical experience with carefully selected, volunteer patients has indicated that, when the amino acid content of a tumor is determined through assay, it can sometimes be caused to regress when the patient is fed a diet that is deficient in the specific amino acids that the tumor requires. Of 30 patients so treated, the investigators said, 20 had experienced comfortable prolongation of life from four to 22 months. Patients were not selected for the experimental diet-therapy program unless usual clinical procedures had been proven inapplicable.

Basic research which seeks the cause of cancer may get a boost from the work of another team of



OF CANCER RESEARCH

investigators, who worked out the intricate molecular structure of the enzyme ribonuclease.

David Harker, PhD, who has been studying the enzyme's protein structure for 16 years, commented in announcing the results of the investigation:

"The life process depends upon the orderly behavior of complex forces acting within protein molecules, and their interactions and reactions with neighboring molecules.

"It is possible that, when the atomic structures of proteins are altered in some manner, there may be a relationship to cancer."

Ribonuclease is a protein, as are most enzymes.

Dr. Harker is director of the Center for Crystallagraphic Research at Roswell Park Memorial Institute, Buffalo, N.Y., where he and coworkers conducted the ribonuclease research. More than a half-million reflections were taken of ribonuclease crystals in the investigators' X-ray diffraction unit in order to precisely map the position of the 1,000-plus atoms in the ribonuclease molecule.

Ribonuclease works within the cell to break down ribonucleic acid, and thus exert a control on cell growth; at the cell's death, the enzyme acts as a "housecleaner" to remove freed ribonucleic acid.

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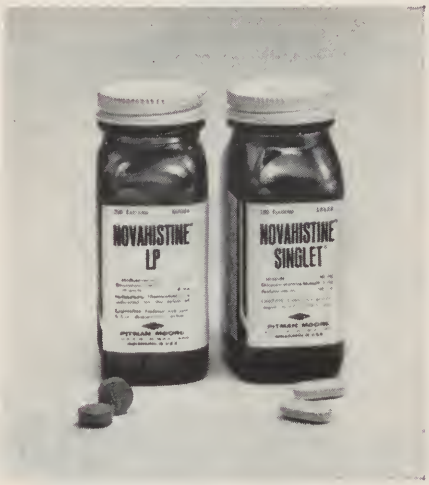
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Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

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Panel Discussion on
The Syndrome of Transexualism

Church Home and Hospital Auditorium
Friday, March 1, 1968, 8:30 P.M.

JOHN E. HOOPES, MD, *Moderator,* Assistant Professor of Plastic Surgery, The Johns Hopkins University School of Medicine.

Panel Members:

MILTON T. EDGERTON, MD, Professor of Plastic Surgery, The Johns Hopkins University School of Medicine.

NORMAN J. KNORR, MD, Assistant Professor of Plastic Surgery and Psychiatry, The Johns Hopkins University School of Medicine.

DIETRICH P. BLUMER, MD, Assistant Professor of Psychiatry, The Johns Hopkins University School of Medicine.

JOHN W. MONEY, PhD, Associate Professor of Medical Psychology, and Pediatrics, The Johns Hopkins University School of Medicine.

CLAUDE J. MIGEON, MD, Associate Professor of Pediatrics (Endocrinology), The Johns Hopkins University School of Medicine.

HOWARD W. JONES, JR., MD, Professor of Gynecology and Obstetrics, The Johns Hopkins University School of Medicine.

HORST K. A. SCHIRMER, MD, Associate Professor of Urology, The Johns Hopkins University School of Medicine.

* * *

The Board of Directors of the Baltimore City Medical Society met at 1211 Cathedral St., Baltimore, Md., on January 9, 1968 at 4:30 P.M. The meeting was called to order by Dr. Frank Kaltreider. Eight of the members of the Board of Directors were present at this meeting. The minutes of the December 12th meeting were read and approved by the Board. The Board approved the appointments to Emeritus Membership of Doctors Byruth Lenson-Lambros, Ernest L. Stebbins and

J. Wesley Edel. The Board decided that no nominee for the Community Service Award be submitted for 1968. The Board plans to make arrangements with the hospitals designated for the general meeting for the serving of refreshments after meetings.

Dr. Kaltreider read a letter sent him by Howard Moses, Chairman of the Legislative Committee of the Baltimore City Medical Society suggesting that a closer liaison with the Baltimore City Council in regard to legislative matters in the city of a medical nature be brought about. He suggested this could be done by the selection of a qualified member to serve in this capacity. After some discussion, the Board decided to contact Dr. Emerson Julian, a member of the City Council, to serve in this capacity.

Dr. Kaltreider announced that the Baltimore City Health Department expressed a need for physician coverage for their Well Baby Clinics in the city.

A report filed by the Professional Relations Committee stated that frequently, when correspondence is necessary between this committee and an individual physician, the physician against whom charges have been levied frequently adapts the attitude of a personal allegation, levied by the communicating member of this committee. The Board would like the membership to be reminded that the actions of this committee are not levied by any single individual serving on this committee, since these judgments are the combined opinion of the professional relations committee as a group. It is hoped that in the future the membership will interpret such criticism as "the opinion of this committee" and not those of the individual member acting as the communicative officer.

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Committee on Public Medical Education and Public Relations

ISRAEL ZELIGMAN, MD, *Chairman*

Marriage, Divorce and Mental Illness
(Arranged by Emmanuel A. Schimunek, MD)
Sunday, March 3, 1968, 1:30 P.M.

Dental Program
(Arranged by the Baltimore City Dental Society, William Schunick, DDS, President)
Sunday, March 10, 1968, 1:30 P.M.

Regional Medical Program of Maryland
(Arranged by Charles E. Carr, Jr., MD)
Sunday, March 17, 1968, 1:30 P.M.

Trauma, Neglected Disease of Modern Society
(Arranged by Edwin H. Stewart, Jr., MD)
Sunday, March 24, 1968, 1:30 P.M.

One Hundred Years of Surgery since Lister
(Arranged by William Schuman, MD)
Sunday, March 31, 1968, 1:30 P.M.

WASHINGTON-BALTIMORE SOCIETY OF PHYSICAL MEDICINE AND REHABILITATION

Thursday, February 29, 1968, 8:00 P.M.

First Annual Charles S. Wise Memorial Lecture.

Speaker: Mieczyslaw Peszczynski, MD, Director of Emory University Rehabilitation Research and Training Center, Emory University School of Medicine, Atlanta, Georgia.

Subject: Advances in Rehabilitation of the Hemiplegic Patient.

Place: Auditorium of the District of Columbia General Hospital.

MARYLAND SOCIETY OF ANESTHESIOLOGISTS

Tuesday, March 5, 1968, 7:30 P.M.

Speaker: Morris L. Heller, MD, Department of Anesthesiology, Mary Hitchcock Memorial Hospital, Hanover, New Hampshire. (Subject to be announced.)

Joseph S. Redding, MD, *President,* Gerald J. Carroll, MD, *Secretary*

ANESTHESIA STUDY COMMITTEE

Tuesday, March 26, 1968, 7:30 P.M.

Joint Anesthesia Study Committee of the Baltimore City Medical Society and the Baltimore City Health Department.

MARYLAND PSYCHIATRIC SOCIETY

Thursday, March 14, 1968, 8:30 P.M.

Joint Meeting with the Maryland Association of Private Practicing Psychiatrists

Wendell-Muncie Award-Winning paper.

Francis McLaughlin, MD, *President,* Eugene Brody, MD, *Secretary*

PATHOLOGY SECTION

Monday, March 18, 1968, 8:00 P.M.

Discussion of Blood Gases. (Illustrated.) Edward L. Sherrer, Jr., MD, Pathologist, North Charles General Hospital, Baltimore, Maryland.

Edward L. Sherrer, Jr., MD, *President,* William J. Hicken, MD, *Secretary*

MARYLAND ORTHOPAEDIC SOCIETY

Monday, March 11, 1968

Scientific Program by the University of Maryland Hospital and Kernan Hospital Staff. (Time and place to be announced.)

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SECTION ON INTERNAL MEDICINE

Monday, March 25, 1968, 8:15 P.M.

Problems in Staphylococcal Disease. (Illustrated.)
David E. Rogers, MD, Professor and Chairman of the Department of Medicine, Vanderbilt University Medical School and Hospital, Nashville, Tennessee; newly appointed Dean of the Medical Faculty and Vice-President (Medicine), The Johns Hopkins University School of Medicine and Medical Director of The Johns Hopkins Hospital.

Lester Wall, Jr., MD, *President,* J. Rollin Otto, Jr., MD, *Secretary*

FREDERICK COUNTY MEDICAL SOCIETY

The Frederick County Medical Society held its annual election meeting and oyster feed on December 19th, 1967.

Rex Martin, MD, was elected and installed as our new President succeeding Richard L. Fruth, MD, who had served us for two years.

Other officers elected to support Dr. Martin were: Ernest Dettbarn, MD, President-Elect, Fred Baker, MD, Treasurer and A. A. Pearre, Jr., MD, Secretary.

Our January meeting was noteworthy for two reasons. We were privileged to have as our distinguished guest speaker George Yeager, MD, and as a bonus, we were introduced to the very nice and new Red Horse Restaurant in Frederick. Dr. Yeager's talk and the fine food were enjoyed by all present.

Robert S. Turner, Jr., MD
Journal Representative

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this issue: the cold in pregnancy...

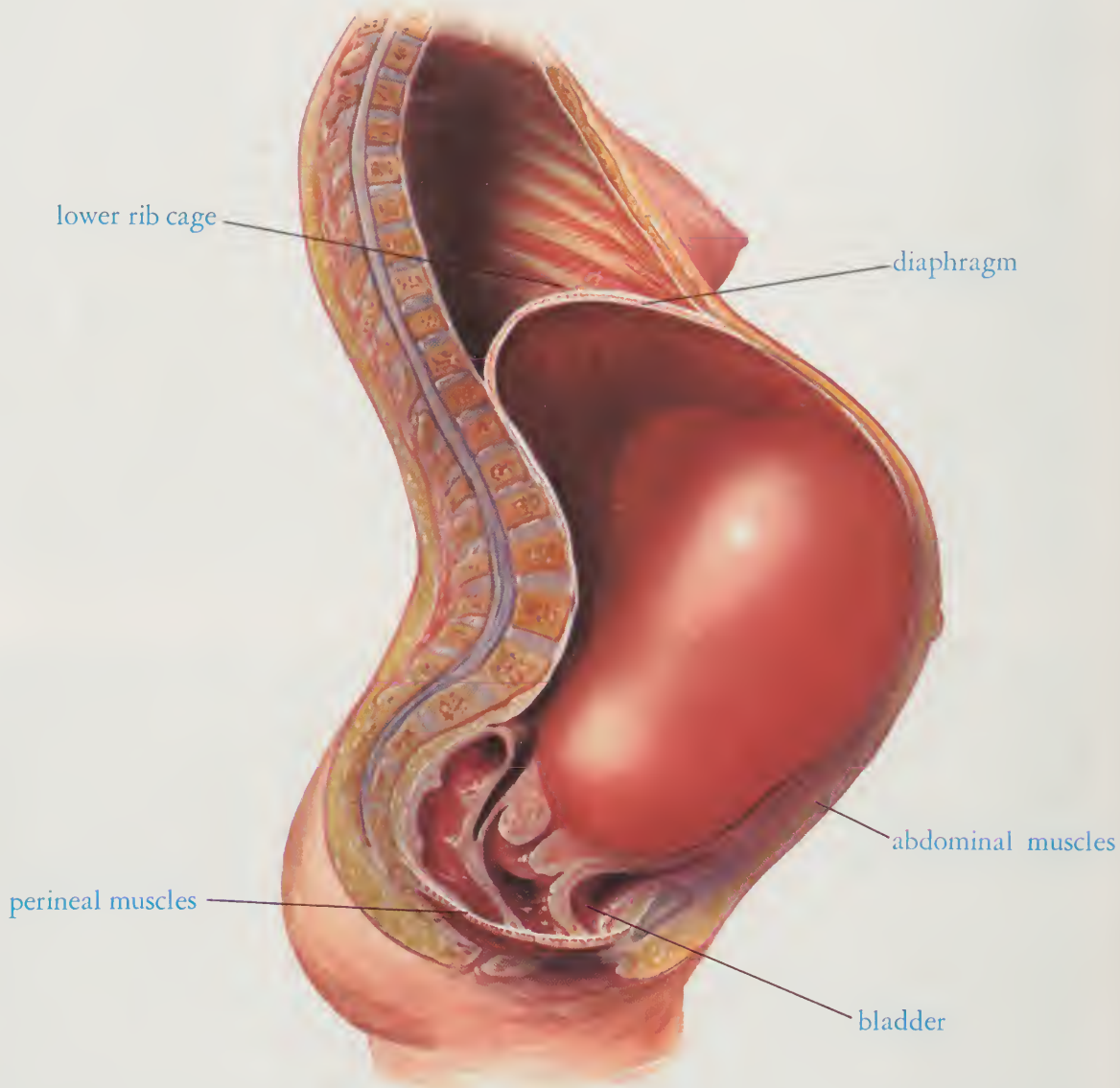
the cold in pregnancy

Frederick W. Goodrich, Jr., M.D.
Senior Obstetrician and Gynecologist, Lawrence and Memorial Hospital, New London, Connecticut

Since pregnancy and the common cold are both ubiquitous, it is not surprising that they often occur at the same time in the same patient. Incidence figures are hard to come by, but the chances are very good that any given pregnant woman will have a cold at some time during the nine months of her gestation. When she does, she will tell you that it is the worst cold she ever had. It seems to last longer and the symptoms are more distressing than they are in the non-pregnant.

For purposes of this discussion, the common cold is considered to be the well-known symptom complex which includes sore throat, stuffy nose, and a cough. Febrile states or extension of the disease process into the lower respiratory tree are not part of the common cold and will not be included in this discussion.

The clinical picture of a cold in pregnancy can be confused by a long-known physiological phenome-



non. Kiesselbach's area in the nose (on the anterior part of the nasal septum above the intermaxillary bone) becomes engorged, apparently due to hyperemia induced by the increased estrogen level which accompanies pregnancy. The amount of congestion can vary in degree from woman to woman. Some have very little congestion, others will have occasional nosebleeds from this area, still others will have symptomatic congestion to the degree that they will complain of having a "chronic" or constant cold.

Less well recognized is the occurrence of this type of hyperemia in any part of the nasopharyngeal mucosa, again in varying degree. Such swelling often produces a postnasal drip which, the patient will state, is present only when she is pregnant. Patients who do not have symptomatic congestion ordinarily, will find that when they do get a cold, the symptoms last much longer than those of a cold usually do. Occasionally, this hyperemia is responsible for closure of the medial end of the Eustachian tube; such patients will complain of "plugging" of the ears. Inspection of the ear drum will show a depression which confirms the presence of Eustachian closure rather than wax in the canal which is the patient's diagnosis. Symptoms related to this physiological congestion are more apt to occur in heavier smokers or those who have a history of allergic rhinitis, just as are the symptoms of the common cold. And when the cold does occur in pregnancy, the symptoms are worse because of the underlying congestion.

The pregnant woman with a cold is miserable for other reasons, dependent somewhat on her parity and the length of her gestation. As parity increases, so also does the relaxation of the abdominal and perineal musculature. The uterus, lying against a slack abdominal wall, and bearing down on relaxed perineal muscles, acts like a piston when the patient coughs, sneezes, or even blows her nose, pushing down on the bladder. Stress incontinence during colds is almost the rule.

As the length of gestation increases, so does the size of the uterus. As it grows, it pushes the abdominal contents above it and elevates the diaphragm. This results eventually in a lateral displacement of the lower rib cage, often to a point at which the patient will complain of soreness in this area. If such a

(Concluded on following page)

From a continuing study on nasal congestion...



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A study begun in 1966 by the Department of Otolaryngology, Greater Baltimore Medical Center, has accumulated evidence that documents the effectiveness of Triaminic's timed-release action in the treatment of nasal congestion.

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Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

(Advertisement)

patient has a cold, the coughing and sneezing will exaggerate this soreness. The diaphragmatic restriction caused by the enlarging uterus also makes breathing more difficult, particularly when the patient lies down. A cold compounds this difficulty.

Treating a cold in pregnancy requires two additional considerations. The patient should be told that the symptoms may last longer lest she become discouraged, and she should be reassured that the treatment will not damage the fetus. Although there are still some women who seem blissfully ignorant regarding matters of health (and these need to be cautioned not to take medication recommended by friends), most of our maternity patients are aware of the thalidomide tragedy. These women need constant reassurance that the symptoms of a cold can be treated, and that the medication is safe. Fortunately, many of the drugs which are of benefit have been in use long enough and widely enough so that such a statement can be offered. Occasionally one encounters a patient who is so anxious to avoid medication that she is extremely reluctant to take anything at all. Since cold is self-limited, it seems reasonable enough to give such a patient the choice and not to force drugs on her if she is obviously afraid of taking them.

The most distressing symptom of the common cold is the nasal congestion. This can be mitigated by the use of a decongestant which will help reduce the postnasal drip and the coughing caused by it. The kind of a cough which is described as a "tickling" in the throat and which is apt to occur when the patient goes to bed is usually due to nasopharyngeal congestion rather than inflammation in the lower respiratory tract.

There are many cough mixtures available. Most contain an antihistamine, a decongestant, and a cough "suppressant." Should cough suppression be desirable, it is important to remember not to use both a decongestant tablet and such a cough mixture as the patient would be getting a double dose of the decongestant. With some patients, the placebo effect of a cough syrup may be important and a liquid preparation might be substituted for an oral tablet.

For a sore throat, candy drops or lozenges at frequent intervals are soothing. It is not only unnecessary but unwise to use antibiotic lozenges or drop The use of antibiotics in an uncomplicated cold contraindicated and should be scrupulously avoide

In summary, a cold in pregnancy is more severe an longer lasting. The treatment of the symptoms wit local and systemic decongestants will make th patient more comfortable.

Apparently the cold is so common in pregnancy th it has received very little attention in the literatur References are almost non-existent and the fe which are available add little to the common know edge, are out-dated, or are not helpful. Thus th usual bibliography is not appended.



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Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
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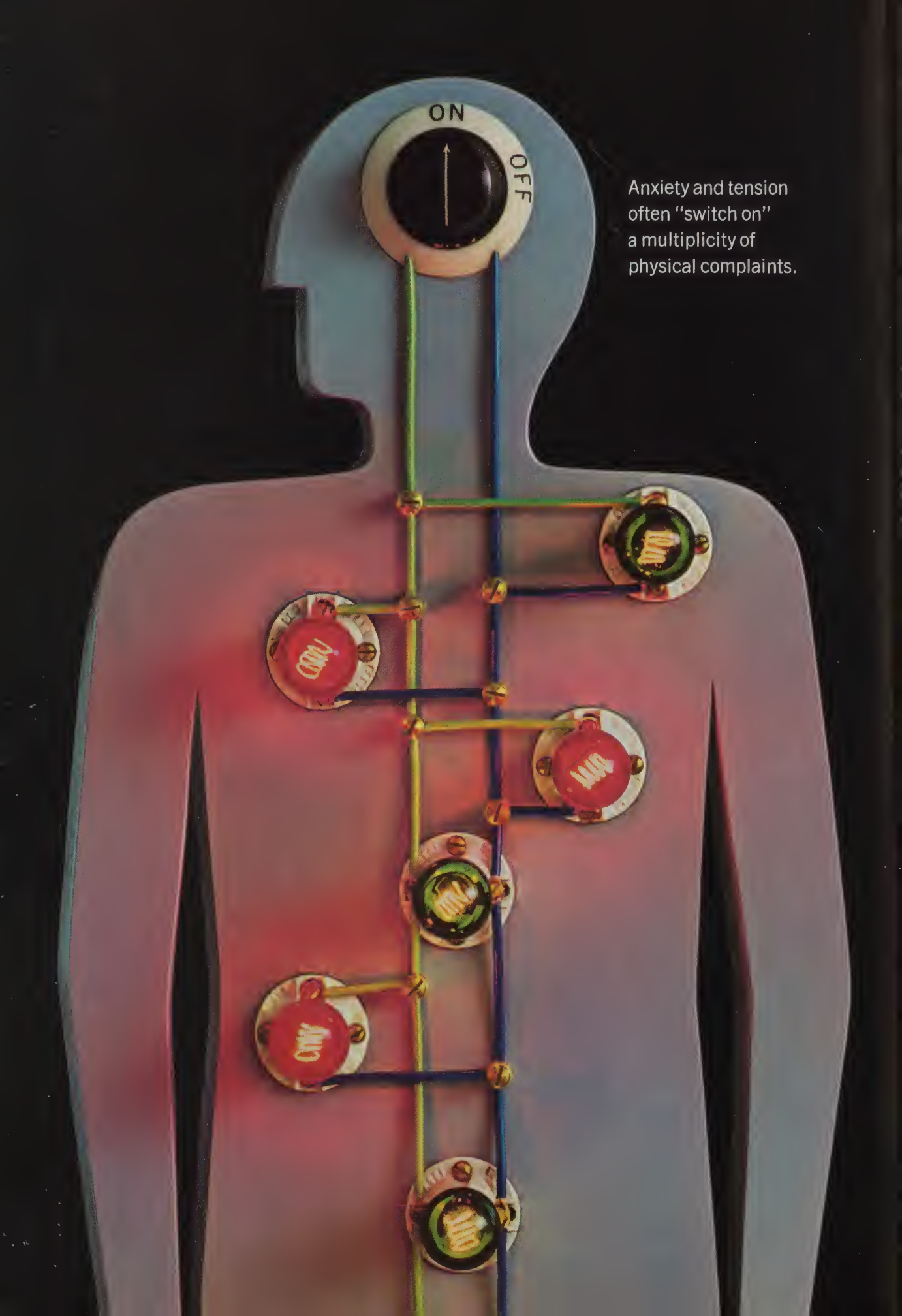
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Two salient features seem to set Tybatran somewhat apart from certain other commonly used tranquilizers.

1. Tybatran often proves more effective than meprobamate and chlordiazepoxide. In one study,[4] severe anxiety responded more effectively to tybamate than to meprobamate; in another,[8] symptom-response superiority of tybamate over chlordiazepoxide was marked at statistically significant levels of confidence.

2. Tybatran appears to be less sedating than other widely used tranquilizers. Side reactions are relatively infrequent; when they do occur, they may take the form of drowsiness, although insomnia, ataxia and other adverse effects have been reported. Nevertheless, Tybatran impresses many clinicians by its comparative lack of undesirable sedative action.[3,6,12,13] (If drowsiness or vertigo is present, activities requiring optimal alertness should be avoided.)

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Dosage and administration. The suggested adult dose of Tybatran (tybamate) is one or two 250 mg. capsules three or four times daily. Dosage should be adjusted to suit individual requirements. While clinical experience with Tybatran (tybamate) in children has been very limited to date, the recommended daily dosage for children 6 to 12 years old is 20 to 35 mg./kg. body weight, in three or four equally divided doses. Dosage should be adjusted to suit individual requirements. Until further clinical experience is obtained, administration of Tybatran (tybamate) to children under 6 years of age is not recommended. Daily doses larger than 3000 mg. are not recommended, although in a few instances doses in excess of this figure have been administered. Tybatran (tybamate) is also available in 350 mg. capsules, for convenience in dosage adjustment, e.g., one capsule three times daily and two at bedtime.

Contraindications. Tybatran (tybamate) should not be administered to patients known to be hypersensitive to the drug. Since no studies have been done with this drug in human pregnancy, it should not be used in pregnancy unless the potential benefit outweighs the risk.

Warnings. Simultaneous administration to psychotic patients of tybamate with phenothiazines and other central nervous system depressants has in a few instances been associated with the occurrence of grand mal or petit mal seizures. Seizures have been reported with administration of phenothiazines alone, but not with administration of tybamate alone; nevertheless, tybamate should be used cautiously in individuals who are receiving other central nervous system depressants or have a history of convulsive seizures. Also, it should be borne in mind that simultaneous administration of tybamate with alcohol or with other psychotropic agents, particularly phenothiazines or monoamine oxidase inhibitors, which are known to potentiate the action of other drugs, may result in additive actions.

Precautions. There has been no evidence to date of the development of habituation or addiction. Investigators have not observed excessive self-medication or any withdrawal symptoms with use of Tybatran (tybamate), but the latter should be kept in mind with cessation of the drug after prolonged use. Because of the occurrence of

Prescribing information continued on next page.

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Prescribing information continued from preceding page.

withdrawal symptoms or exacerbation of presenting symptoms upon rapid withdrawal of other agents of this type, abrupt withdrawal of Tybatran (tybamate) should be avoided. Tybamate, like other psychotherapeutic agents, should be used with caution in addiction-prone individuals. Should symptoms of hypersensitivity occur, administration should be discontinued at once and appropriate symptomatic treatment initiated. Operation of motor vehicles or machinery or other activities requiring optimal mental alertness should be avoided if drowsiness or vertigo is present. As with any new drug, Tybatran (tybamate), should be used with caution in patients with a history of drug allergies, blood dyscrasias, and hepatic or renal disease; and prolonged and/or high doses of tybamate should be accompanied by periodic measurements of hepatic, hematopoietic, and renal function.

Adverse reactions. While these have only rarely required discontinuation of the drug, the most frequently encountered reactions have included drowsiness, dizziness, nausea, insomnia, euphoria. The drug was discontinued in one child because of a possible drug-induced urticaria, and skin rash and pruritus have been encountered in a few other patients. In a few patients, effects suggesting excessive stimulation such as hyperactivity, fidgetiness, flushing, and tachycardia have been encountered. Other reported side effects recorded only a few times to date have included ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients to whom tybamate (up to 6000 mg. daily), phenothiazines, and other psychotropic agents were administered simultaneously. Convulsive seizures have not been reported with the use of tybamate alone.

Until clinical experience has accumulated with this drug, inasmuch as tybamate is related to meprobamate, the physician should be cautious about the possibility of rare, serious adverse reactions such as may be encountered with the latter drug. Should excessive doses of tybamate be ingested, it is recommended that any drug remaining in the stomach be removed and symptomatic therapy, including central stimulants, be used as necessary.

Supply. Tybatran (tybamate) is available in green, sealed capsules of three strengths: 350 mg., 250 mg., and 125 mg. Each strength is supplied in bottles of 100 and 500.

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MEDICAL EDUCATION

Five new medical schools opened during the fall of 1967. Others increased their enrollments of beginning medical students.

The result is an increase of first-year medical students to an estimated 9,280, compared with 8,964 last year, according to the *AMA News*, published by the American Medical Association.

The new medical schools are the University of Arizona College of Medicine, at Tucson; Brown University's Program in Medical Science, at Providence, R.I.; the University of Hawaii School of Medicine, at Honolulu; Michigan State University's College of Human Medicine, at East Lansing; and, Pennsylvania State University's Milton S. Hershey Medical Center, Hershey, Pa.

The five new schools raise the number of U.S. medical schools to 94. Eleven other new medical schools are continuing development programs. By the mid-1970s, medical schools will be graduating about 10,000 students annually.

The *AMA News* warned editorially that the statistics should not be celebrated as marking a solution of medical manpower shortages.

"The American Medical Association's Board of Trustees has stated that while medical school output will continue to increase steadily, the increase will probably not be sufficient to resolve the medical manpower shortage," the editorial said.

"Medical educators know it takes from six to ten years from the time it is decided to build a medical school until the graduation of the first class. It requires a minimum of three years after money is available to develop a medical school to the point where it will enroll its first class."

The five new schools "can serve as inspirations," the editorial said, but they ought to serve as warnings that "the time to act—the time to begin planning and gaining the necessary support for a new school or the expansion of an existing one—is now."

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EDITORIAL

Maryland State Medical Journal
Vol. 17, No. 2
February, 1968

On Medical Ethics

Frequently we hear physicians say they are not concerned with the specifics spelled out in regard to medical ethics. To them, practicing medicine according to their own standard of ethics is good enough.

The defensive comment, "I am not bound by what those who have no personal contact with my patients say I should do," is usually the reply to the Faculty's Mediation Committee when a physician has been advised that he has, indeed, been unethical in his dealings with his patients or other members of the profession.

Since the end of World War II, there has been an increasingly conscientious attempt to adequately police violations of ethics and to take action against the small percentage of offenders. The American Medical Association recognized the need for a written code of ethics and directed its Judicial Council to prepare one.

The task has been immense, as the conduct of the physician is subject to more laws, rules and regulations than any other profession in this country today. As a citizen, the physician is expected to obey all of the statutes and court decisions that apply to the public at large; as a specialized member of society, the physician is expected to abide by the provisions of the medical practice act governing the practice of medicine in each of the states; as a member of an organized profession, the physician is expected to abide by a self-imposed code set forth in the Principles of Medical Ethics of the American Medical Association; as a hospital staff member, the physician is expected to observe the rules and regulations promulgated by the hospital staff; and as a member of an old and honored profession, the physician is expected to live up to the public's subjective concept of how a doctor of medicine should look and act.

In a single issue of the JOURNAL, one could not hope to include sufficient materials on each of these aspects of medical ethics and discipline to enable anyone using it to make an exhaustive study of each. The goal of this issue is to furnish guidelines for the activities in which medical associations are engaged and to encourage physicians, active in organized medicine, to review and, where necessary, to make disciplinary practices more effective.

It is not enough for a physician to claim he practices medicine according to his own moral judgment, nor is it enough for a physician to assert he is above the criticism of his peers.



(The material included in this section of the JOURNAL has been excerpted from the American Medical Association's Manual, *Medical Ethics and Discipline,* compiled by the Office of General Counsel, 1965.)


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Objectives of the Program on Medical Ethics

To stimulate the interest of the individual physician in the area of medical ethics and to encourage him to make this area more relevant and meaningful in his professional life in order that he may more nearly exemplify the finest traditions of the medical profession.

To improve and make more efficient grievance and disciplinary procedures and practices in all areas of the profession.

To give leadership and guidance to physicians to assist them in resolving moral problems of a professional nature.

To give leadership and guidance to the profession by anticipating and resolving ethical problems before they become acute to the extent that this is feasible and appropriate.



To enhance the understanding of physicians, lawyers, legislators, other public officials, and the public of the Principles of Medical Ethics and Professionalism.

To encourage physicians in all levels of group and organizational activity of a professional nature, to consider relevant ethical principles when formulating policy programs or procedures.

To promote unity in the profession by encouraging all physicians to be more aware of their common bonds of professionalism and by encouraging them to resolve any differences within, rather than without, the profession.

To promote the concept of professionalism within the medical profession and with other worthy professions.

History of Medical Ethics

The earliest written code of ethical principles for medical practice was conceived by the Babylonians around 2250 B.C. That document, the Code of Hammurabi, was indeed a *code* of conduct, setting forth in considerable detail for that era of history the nature of conduct demanded of the physician. Today that code would be subject to criticism because it went into too much detail. It may be doubted that it could have continued, as a practical document, through the centuries because, as medical science and cultural patterns became more complex, it would have required one skilled in jurisprudence to codify and interpret the myriad situations covered by it.

The Oath of Hippocrates, a brief statement of principles, has come down through history as a living and even workable statement of ideals to be cherished by the physician. This Oath was conceived some time during the period of Grecian greatness, probably in the fifth century B.C. It protected rights of the patient and appealed to the inner and finer instincts of the physician without imposing sanctions or penalties on him. Other civilizations subsequently developed written principles, but the Oath of Hippocrates (Christianized in the tenth or eleventh century A.D. to eliminate reference to pagan gods) has remained in Western Civilization as an expression of ideal conduct for the physician.

The most significant contribution to ethical history subsequent to Hippocrates was made by Thomas Percival, a physician, philosopher, and writer of Manchester, England. In 1803, he published his *Code of Medical Ethics*. His personality, his interest in sociological matters, his close association with the Manchester Infirmary, led to the preparation of a "scheme of professional conduct relative to hospitals and other charities," from which he drafted the code which bears his name.

At the first real meeting of the American Medical Association in Philadelphia in 1847, the two principal items of business were the establishment of a code of ethics and the creation of minimum requirements for medical education and training. Although the Medical Society of the State of New York and the Medico-Chirurgical Society of Baltimore had had formal written codes of medical ethics prior to this time, it is clear from the records and the preface to AMA's first adopted Code of Ethics that it was based on Percival's Code.

In general, the language and concepts of the original Code adopted by the Association in 1847 remained the same throughout the years. There were revisions, of course, which reflect the temper of the times and the eternal quest to express basic concepts with clarity. Major

revisions did occur in 1903, 1912, and 1947. In 1947 the language of the chapter dealing with compensation of physicians, contract practice, conditions of medical service, free choice of physician, and purveyal of medical services was redrafted.

In December, 1955, an attempt was made to distinguish medical ethics from matters of etiquette. A draft of a two-part code seeking to accomplish this was submitted to the House of Delegates at that time but was not accepted. This proposal was, in effect, a segregation of then existing statements, found in the *Principles,* into two categories. Little or no change was made in the language of the forty-eight sections of the *Principles.*

Subsequently, in June, 1956, a seemingly radical proposal was submitted to the House of Delegates for consideration. This proposal, a short version of the *Principles,* was discussed at the following session of the House, in December, 1956, after having had wide publication and broad consideration among members of the medical profession. It was then laid over for final consideration at the June, 1957, meeting of the House of Delegates, at which meeting the short version was adopted.

The format of the *Principles* adopted in June, 1957, is a change from the format of the *Principles* promulgated by Percival in 1803 and accepted by the Association in 1847. Ten short sections, preceded by a preamble, "succinctly express the fundamental concepts embodied in the present [1955] Principles," according to the report of the Council on Constitution and Bylaws. That Council assured the House of Delegates in its June, 1957, report that "every basic principle has been preserved; on the other hand, as much as possible of the prolixity and ambiguity which in the past obstructed ready explanation, practical codification and particular selection of basic concepts has been eliminated."

Almost immediately after the 1957 edition of the *Principles of Medical Ethics of the American Medical Association* was adopted, the Judicial Council of that Association expressed its formal opinion that:

> ". . . the 1957 edition of the *Principles* was not intended to and does not abrogate any ethical principle expressed in the 1955 edition of the *Principles of Medical Ethics of the American Medical Association.* The format and language of the 1955 and 1957 editions differ; certain items dealing with professional manners and etiquette have been eliminated. However, the basic ethical concepts they include are identical. Therefore, no opinion or report of the Council interpreting these basic principles which were in effect at the time of the revision has been rescinded by the adoption of the 1957 edition . . . "

PRINCIPLES OF

PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

SECTION 1

The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

SECTION 2

Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

SECTION 3

A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

SECTION 4

The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

SECTION 5

A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient,

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he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

SECTION 6

A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

SECTION 7

In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

SECTION 8

A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

SECTION 9

A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

SECTION 10

The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Medical Ethics—Choice for Right

HOWARD A. NELSON, MD

"A PHYSICIAN should be an upright man, instructed in the art of healing . . . modest, sober, patient, prompt to do his whole duty without anxiety; pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life."

Thus did Hippocrates write the first principles of medical ethics more than three centuries before the birth of Christ. In less than 50 words of classical Greek, he established the foundation for nearly all systems of ethics to follow, and in 22 centuries of writing and rewriting men have failed to add or take away a single tenet. The Hippocratic essentials are conduct, obligation, character, and aim.

Time has produced only an interweaving of moral declarations, science, and religion. Nothing really new has been added. This suggests something strangely wonderful about the profession of medicine; the manner in which it is practiced predates, by thousands of years, the science actually practiced. But there is then an important distinction to be made between morality and science. Ethical principles are a priori while science is empirical. But this for many scholars, even those who disagree among themselves, is a meaningful interdependence and not a cleavage. The apriorist calls for a distinction between reason and experience where the former consists of eternal principles of validity not derived from the latter. But experience must include morality. Two contemporary scholars of theology and ethics, Brightman,[1] an empiricist, and Knudson,[2] an apriorist, seem most representative of this view.

The young physician must be no less proficient in the humanities than he is in the sciences if he is to succeed in bringing his career into a rich perspective of character and competence. If he is deficient in either, he is not likely to become the doctor his preceptors are striving to make nor the one an enlightened public expects and demands. There is no documentation to back up this notion, but the chances are that no physician grounded in serious training in ethics, morality, philosophy, and religion will find himself before the medical society grievance committee or the board of censors.

Evolution in systems of medical ethics is virtually limited to matters of statement and application. For 21 centuries, they were individually stated and informally applied. During the past 100 years, medical ethics has become a collectively stated proposition formally applied by the body politic to the whole of the profession. Medicine came of age in the 19th century, and Percival's Principles of Medical Ethics in 1803 preceded the organization of the American Medical Association by only 44 years. Although the historic AMA organizational meeting at Philadelphia in May, 1847, had the primary purpose of improving medical education, the founding fathers took time to adopt the first version of the familiar document.[3]

The present Principles of Medical Ethics of the American Medical Association[4] is not even twice as long as the oath of Hippocrates. It is a brief document of scarcely more than 500 words, a substantial reduction from the old 4,000-word

Principles which existed in essentially the same form for 110 years. The chief difference in the versions is the elimination from the older document of the dicta of etiquette and manners formerly intermingled among guides for moral conduct and professional obligation. There is a word to be said for the old Principles which will be all but lost to the next medical generation. (The Judicial Council of the American Medical Association has published an "abstract of opinion" which reproduces all the sections of the 1955 edition of the Principles, correlating them to the 1957 edition.)

At some point early in his professional career, each young physician should read the older version. This is not a plea to reverse the June 6, 1957, action of the AMA House of Delegates at New York, and return to the old. It is an exhortation to the coming generation of physicians to grasp and hold to everything of possible value which the past can provide. Complex society has made uncertain the navigation channels in the turbulent sea of modern professional pursuits, and the lighthouses of moral guidance are altogether too far apart. No thinking medical leader is thus crusading for a return to the horse and buggy doctor so often lionized in the legend of ideals. This is, conversely, a rare opportunity to draw on the riches of the past, while avoiding its error, and to reap the profits of now-apparent mistakes.

Although remembered historically as a symbol of material splendor, Babylonia apparently gave the world the first formalized expression of medical ethics in the Code of Hammurabi. The celebrated code, engraved on a priceless and magnificent stele, now in the Louvre in Paris, contains 282 sections providing for nearly every legal and moral problem of that ancient society. It even spelled out the physician-patient relationship! And that was as far from Hippocrates as his oath is from the 1957 version of the "Principles of Medical Ethics."

From Hammurabi to Hippocrates to New York is just about the history of the world, but the moral aim of the healer is consistent all along the way. The preamble to the Principles of Medical Ethics states, "These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public."

That strength of character is a matter of self-determination obtains with the physician where it fails with others. The Principles are nothing more than a yardstick with which to measure conduct, obligation, and aim. Specifics are generally avoided, giving way to broad guiding principles. Except for eight words in section 5, there is no reference, direct or indirect, to professional freedom. Yet the whole of the document is a declaration of moral freedom—but only freedom to choose the right.

There is never a problem in ethics until the individual is confronted with a choice. Every choice we make commits us to consequences. At the precise instant the choice is made, we reach a point of no return. Some early moral codes provided generously for recalling poor choices through escape and exoneration devices following a determination of guilt.[5]

Roberts tells of a highly respected physician who was sure that lack of scientific medical knowledge had been disastrous to patients he was treating some years previously. The doctor had no fear of punishment and suffered no pangs of remorse because his treatment had been that which the medical profession of the day regarded as correct and acceptable. The doctor had no ethical or scientific alternative.[6] The important question arises, then; what is choice and what kind of situations compel us to make a choice? The answer is both eternal and temporal; morality is eternal, but the conditions of choice are temporal, based on empiricism of existing knowledge. For the ethical physician, there is never a point of turning back nor is there atonement. The choice he makes must stand as his best effort; to do less is to fail ethically.

The 10 sections of the current Principles of Medical Ethics of the American Medical Association deal with medicine's goals of service, improvements in knowledge and skills, and scientific attainment. Further, physicians are exhorted to uphold the dignity and confidence enjoyed by the profession and to safeguard themselves against incompetence within the profession. Responsibility to patients, disposition of services and professional attainment, and sources of income constitute principal ethical limitations. One section

alone is given over to the physician-patient relationship, and a final injunction emphasizes the responsibility of the physician as a citizen and member of society. Sectarian or cultist relationships are strictly prohibited as being unethical.

The first section outlines medicine's aims: "The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion."

The words of Hippocrates ring in this simple and direct statement recalling that the physician should be "modest, sober, patient, prompt to do his whole duty without anxiety." It logically follows that in section 2 is demanded a continual striving to improve knowledge and skills, requiring that benefits of all professional attainments be made readily available to patients and colleagues alike. Thus does American medicine have a moral basis for prohibiting secret remedies and techniques; these are devices of the cultist, usually worthless, if not harmful. Not a few national-level organizations in medicine require certain postgraduate education minimums, thus insuring constant improvement of scientific knowledge and skills. Meetings of the county medical society, state medical association, and AMA are devoted principally to this necessary end.

In section 3 it is required that "A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle." This is the ethical basis for separation of cultism from science, superstition from knowledge. It is unethical to associate voluntarily in any manner with a chiropractor, naturopath, osteopath, or other irregular practitioner. Since 1955, when Resolution No. 77 was adopted by the AMA, the Judicial Council has held it unethical to associate voluntarily with an optometrist.[7]

One of the four cardinal hippocratic principles is specifically covered in section 4, which states, "The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession."

This injunction as to the physician's character raises the question of freedom of choice. More a matter of semantics than of morality, there is no question of being bound or free—only the question of by what the ethical physician shall be bound.[8]

Section 5 contains the only statement of freedom of choice permitting that "a physician may choose whom he will serve." Exception is made to provide for emergencies, and the ethical practitioner is enjoined against neglect of a patient once care has been undertaken. He may discontinue his services, apart from discharge by the patient, only after giving adequate notice. Solicitation of patients is forbidden.

Oddly enough, the sternest requirements of moral and legal responsibility are interwoven with the single statement of freedom. This is the one section of the Principles relating directly to most statutory provisions on patient neglect as well as that of patient solicitation through advertising or other public dissemination of self-laudatory information.

Generally, the basic unit of medical organization—the county medical society—exercises the greatest latitude in interpreting this section. Precisely what constitutes advertising, patient solicitation, and self-laudation is best determined at the local level. Appellate prerogatives are reserved to the state medical association and AMA Judicial Council. The practice of local determination and definition of these unwholesome practices is not to say that the state association is without prerogative of original hearing and ruling; there are many instances where this has, indeed, been done.[9]

Corporate practice and exploitation of a physician through employment arrangements are primary subjects of interest in section 6. It is stated, "A physician should not dispose of his service under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care."

This has been one of the most difficult portions of our system of ethics to interpret and enforce. Many physicians feel that the statement is vague and less than definitive. This lack of definition, however, permits state associations to examine problems in light of local conditions and permits

them to elaborate upon that principle for the guidance of its membership. For example, the Mississippi State Medical Association works through its House of Delegates. This House of Delegates has made the following statement:[10]

> It is essentially undesirable for professional services to be purveyed by hospitals, corporations, and/or political subdivisions where fees for services are involved either from the patient or a responsible third party except for those statutorily established and medically accepted programs of government which are not disapproved by the association.
>
> Reasonably expeditious and conscientious effort should be exerted by all physicians to provide medical services privately, whether gratuitiously or paid, in a climate of free choice, where possible.
>
> Patience and indulgence should characterize the efforts of all concerned to achieve these objectives without unnecessary delay. Litigation and the development of profound differences of viewpoint which, when publicly exposed, tend to lessen confidence of the people in the American system of medical care should be scrupulously avoided.

"In the practice of medicine," section 7 states, "a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies, or appliances may be dispensed or supplied by the physician provided it is in the best interest of the patient."

Here is the one reference to the economics of medical practice in this entire system of ethics. Previously, the older and longer version had a number of references, especially with respect to financial gain being a subordinate objective to that of service. It must be noted that there is no ethical taboo against the dispensing of drugs and appliances, but there is a strong qualification that such action must be in the best interest of the patient. Formerly, dispensing was generally held as unethical; practical experience has demonstrated that this former restriction was not always in the interest of the patient.

Sections 8 and 9 require the exercise of moral judgment by the physician in the pursuit of scientific activity. The former requires that a physician seek consultation upon request, in doubtful or difficult cases, or whenever it appears that the quality of medical service may be thereby enhanced. Here is a situation where the physician must make a qualitative evaluation in ethical judgment.

Section 9 makes it incumbent upon a physician not to "reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community."

Finally, in the Principles of Medical Ethics the physician is required to have a balance of conscience and a proper investment of emotional and civic capital. It states, "The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community."

Perhaps the best commentary would be to say simply that the doctor must also be a citizen. It is good advice to the doctor for him to seek the ideal balance in community and professional living which avoids an exaggeration of moral consciousness just as it does that of incompetence. The heritage of medicine is rich, but the exacting requirements on the disciples of a sometimes inexact science make doctors servants of a "jealous mistress."[11]

To give your career to medical science, you must give your life to morality and dedication.

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Medical Ethics and some of its Problems

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From the very beginning of the practice of medicine, physicians have adhered to certain ethical concepts even before they were expressed and reduced to writing. This has been true because medical ethics are basically the same as the ethics for any other homologous group of people working together in a common cause. They differ only in specialized particulars concerned with the service or activity which may be unique to a particular group and of little or no concern to another.

Ethics are principles. They represent generations of experience by trial and error. As such they are blueprints for the practice and behavior of the individuals who make up the group. They distill the best of the past, sustain the needs of the present and point to the possibilities for improvement of the future.

All too frequently of late a distinction was being made between conduct that was "unethical" and conduct that was "contrary to the Principles of Medical Ethics." Such rationalization is erroneous. All men are guided by the same ethical principles and conduct is ethical or unethical as it is or is not in accord with basic principles. The reason for principles of medical ethics is to accent basic, universal and permanent ethical principles which have particular application in the practice of medicine. They do not carve out exceptions to basic ethical concepts.

While it is said with some truth that the honest, conscientious doctor does not need a written code of ethics, it must be admitted that one can act from a right conscience only if he has a right conscience. And it must be recognized that there are occasions when conscience may be doubtful.

The high opinion in which the profession is held by the public is due in large measure to the wholehearted manner in which the great mass of physicians have conducted their professional life in accordance with the accepted Principles. The Principles have always stressed that the duty of the physician is to his patient. They remind him of the full responsibility that is his, once he has accepted the patient. They also point out that the physician is free to choose whom he will serve but that he also should respond to any request for assistance in times of emergency, or whenever public opinion expects the service.

The tragedy is that there are a few doctors who put aside any idealism they might have had, and work only for their own financial betterment. It is this small group that aids in stimulating the growth of insidious, indiscriminate smearing of doctors as a class and the general disparagement of all of our profession's ideals.

While hundreds of doctors do thousands of dollars worth of work without receiving any fee, there are a few who overcharge the patient. This group fails to realize that by making money their supreme goal, they are cutting off their own nose. They don't realize that sooner or later it will become known that they indulge in sharp practices, and their patients will lose trust in them and go elsewhere. However, as a well-known surgeon said many years ago, "Let us brush the dust of hypocrisy from our knees and admit that learning is, in part a commodity." Most of us depend upon this commodity for our living and

we thus earn our daily bread. While we earn our daily bread, however, we can see to it that our conduct is such that it will not bring criticism on ourselves or on our profession.

We have our faults and our virtues. We meet with failures and achieve successes. Many of our faults are entirely unavoidable and arise from the fact that medicine is not an exact science. We must recognize our limitations; we must be able to distinguish between what we know and what we simply guess; we must be able to recognize the essential and fundamental from the non-essential and accidental; we must cease to confuse vague hypothesis with established fact.

Sir William Osler said, "Let the doctor pay heed to his education and ethics and his reputation will take care of itself." This philosophy is one followed by the vast majority of physicians and pays rich dividends in the end. Today, more than ever before, medicine is in the public view. We see it on TV and in the magazines and daily press, and hear about it on radio. Much of this is good but a certain amount is stimulated by aggressive, irresponsible individuals who would like to destroy the very system upon which the free practice of our profession is based. There is a great deal of unrest, and predictions of the future are constrained and narrow. This means that it is more important than ever that the physician adhere to his ideals.

It is this sort of idealism which has always led the public to rank medicine with the ministry. Like the minister, the physician has the traditional moral responsibility of "going the second mile"—of rendering care over and above the call of duty, to rich and poor, just and unjust, friend and foe alike.

Medical ethics face their greatest crisis when the young man or woman leaves college. The world of actual practice gives them a rude shock.

The young doctor quickly learns that in the practical affairs of life, ethics and economics overlap. His idealism leads him to place ethics first. His desire for economic gain often sets up a sharp conflict of purposes. Nowhere is this relation between ethics and economics closer than in medicine; nowhere are the issues between the two more important.

There are a few important points that seem to lead to confusion in the minds of many physicians and laymen alike. Most of our problems originate in the area where ethics and economics tend to overlap.

Free choice of physician is an expression used to reflect at once both an economic and an ethical principle. Simply, it means that it is the inalienable right of the patient to choose the doctor he prefers and to change physicians when he feels he is not receiving satisfactory medical care. Obviously the application of this right is not absolute. Natural factors limit it. There may be only one physician in a community. Or, the physician chosen may not choose to accept the patient. Civilians, for example, cannot choose Army doctors.

These limitations of application must be kept at a minimum. Arbitrary or economic limitations on the patient's exercise of his inherent right to choose his physician are detrimental to the patient's medical welfare.

The areas in which we have the greatest problem are in the case of certain panel groups employed by some insurance plans and by certain industrial groups.

There are many industries which choose certain doctors in a given area to care for their employees in that area.

The industry being of the opinion that if they are paying for the service they have the right to make the choice. There are many variations to this situation but all have to do with "free choice." It is my opinion that to choose your own doctor is your inherent constitutional right to be exercised, or not, as you wish.

The public, forgetful that all that glitters is not gold, tends to accept without critical evaluation any new service or product if it is sufficiently publicized and promoted. It is prone to accept proposals claiming professional services can be obtained wholesale, according to the practices of the commercial world.

Members of the medical profession do not believe that professional services can be bought, sold, packaged, stored, delivered, appreciated or depreciated, as a commodity in trade. Members of the medical profession, however, subscribe to the principle that the prime objective of the profession is to make medical service ever more readily

available, and always available to him who needs it regardless of cost.

Both medicine and the public desire the same end and thus it is strange that misunderstanding arises as to the end that is sought. The public is impatient. It wants to take the time element out of orderly social and professional development. Medicine, more critical of the end sought, is more critical of the means used to reach that end and is more patient. Doctors, and perhaps lawyers too, know how important time can be.

To the medical profession "free choice of physician" is a fundamental issue. To some of the public and to some public figures this is said to be a selfish shibboleth; and some commercially minded interests are ridiculing the concept. Although the issue is primarily an economic one it has ethical overtones.

Perhaps there has been a failure of communication between the medical profession and the public it serves. The same type failure may plague you and your profession as social planners tell the public how your professional services should be made available, not according to professional ideals, but according to laws of the market place.

Physicians have not found in their collective experience that the quality or quantity of medical care increases when some third party chooses the individual's physician. Physicians have found that the intervention of a third party may disrupt the intimate, close, personal relationship which is so important to both the art and science of medicine. In this area the concept of free choice has ethical implications.

MEMBERS of the medical profession know, as the public should know, that good medical care cannot result when a designated doctor is limited to giving the patient only what the patient paid for. Medicine must give what individual independent professional judgment dictates.

Our Principles of Medical Ethics recognize that we cannot and may not dispose of our professional services under terms or conditions which tend to interfere with or impair the free and complete exercise of medical judgment and skill or tend to cause a deterioration in the quality of medical care.

The matter of free choice of physician has another aspect which should be of interest to you. In a limited, special sense medicine is competitive. But the competition is cooperative and altruistic. Each doctor competes with himself and with his colleagues so that each procedure is an improvement over the last. As professional men, you recognize the sense of this competition. You agree it is an intangible but integral component of professionalism.

Where this idealistic and healthy competition flourishes, the art and science of medicine flourishes. This competition flourishes in the United States. The principle of free choice, the knowledge that a patient has chosen you, stimulates and actually forces improvement. If you need proof of this just recall that the medical centers of Austria, Germany, England, and France, where a patient's choice has been limited, no longer stand preeminent. Today's doctor does not go to Vienna or Paris for post-graduate work. He comes to your community in the United States.

The right of a patient to choose his doctor, within normal limitations, is one of the vital contributing factors to the status of leadership acquired by the medical profession in the United States. The sum total of all practice of all doctors accounts for the stature of the profession. Free choice exercised countless times, every day effectively prevents the individual doctor from resting on his laurels and past achievements. It lifts the entire profession through the collective achievements of its members.

Medicine's job today is to re-awaken the public to the importance of this concept. At the moment, commercially minded groups, social planners, do-gooders, and others are promoting wholesale medicine, promising that a package deal will save money and provide security. Patients are like clients. They listen to rosy promises without thought of the cost they pay. The money they save will be of little worth if health has been sacrificed to obtain it.

The division of fees, or fee splitting, is another area in which we have difficulty. Our ethics adhere to the principle that you should not collect money for something you did not do. Such a principle could well be adopted by all professions and trades. We can look around us everywhere and see people getting paid all out of proportion to the amount of work they do and in fact getting paid for no work at all.

It is unethical to stand in with the surgeon at the

operation in order to get part of the fee for assisting. It is, however, right to be present at the operation and charge a fee if the patient requests the physician to be there and to visit her following the surgery. This fee must be separate and distinct from that of the surgeon. There are all sorts of ways to juggle a patient, most are unethical.

Then there are rebates, kickbacks, commissions, etc. the practice of which is unethical and if left unnoticed can well get out of hand. This practice can be manipulated in various ways. For example, a druggist might offer to pay office rent if the physician channels all prescriptions through his drugstore. A group or clinic with a building may rent to a druggist on a sliding rental scale. The rent depending upon the profit made by the druggist on the prescriptions from the group. A firm which grinds lenses and makes glasses may give a rebate to the ophthalmologist who prescribes the glasses. In like manner, the orthopedist who prescribes braces, corsets, artificial limbs, crutches and the like may receive a rebate from the appliance manufacturer. All these things are unethical because if it were permitted the temptation would be for the doctor to send his patients not where they could get the best service for the least cost but to the company who would give him the largest kickback. To give the doctor a good rebate it would be necessary to charge the patient more for his prescription or appliance.

Advertising is another area in which physicians are misunderstood and have difficulty. The Principles of Medical Ethics do not proscribe advertising as such; they proscribe the solicitation of patients. Advertising in its broad sense means the action of making fact, information or intention known to the public. Solicitation as used in the Principles, means the attempt to obtain patients by persuasion or influence. The public is entitled to know the names of physicians, the type of their practice, the location of their office, their office hours and the like. The doctor may ethically furnish this information through the accepted local mediums of advertising which are open to all physicians on like conditions. Telephone listings, office signs, professional cards, dignified announcements—all are acceptable mediums of making factual information available to the public.

The public is eager to hear and learn all it can of the most recent advances in the cure of diseases that so far have baffled the efforts of men to cure; it is eager to hear of the brilliant operations by which men have seemingly been saved from certain destruction and brought back to useful existence. It is anxious to learn and put in practice the best methods of public hygiene and preventive medicine. The public press has correctly considered such subjects as news, as that is what interests its daily readers, but the medical profession has been placed at a disadvantage . . . we must realize that if the AMA endeavors to arouse public interest in medical matters and increase the knowledge of public health and hygiene, with this increased knowledge will come a demand for more knowledge concerning the various diseases which may be acquired by any individual. The daily press has a right to publish that which is of interest to its readers; hence it has a right to a knowledge of medical matters that shall be accurate and given by honorable men. On the other hand; there is every reason why the medical profession shall keep up its barriers against the self-advertising of individuals for selfish purposes.

By purveyal of medical services we mean the providing of medical services by a third party for profit to himself at the expense of the doctor, or the profiteering on medical care by a third party. This third party may be a person or a hospital or a corporation.

With regard to the practice of medicine by corporations it is our opinion that such practice is detrimental to the best interests of scientific medicine and of the people themselves. When medical service is made impersonal, when the humanities of medicine are removed, when the coldness and automaticity of the machine are substituted for the humane interest inherent in individual service and the professional and scientific independence of the individual physician, the greatest incentive to scientific improvement will be destroyed and the public will be poorly served.

The Judicial Council believes that the remedy for the evils associated with contract practice resides in the county medical societies. These societies should use influence and power not to condemn the physician who must take the contract by ostracizing him but to prevent underbidding for these contracts below what would give fair reward for medical services rendered.

Medicolegal

Code of Cooperation

Preamble

Acknowledging that substantial part of the practice of law and medicine is concerned with the problems of persons who are in need of the combined services of a lawyer and a physician; that the public interest and individual problems in these circumstances are best served only as a result of cooperative efforts of all concerned; that members of both the legal and medical professions share an obligation to the individual and to society, we the members of the Maryland State Bar Association, the Baltimore City Bar Association and the Medical and Chirurgical Faculty of the State of Maryland, do adopt and recommend the following declaration of principles as standards of conduct for attorneys and physicians, in interrelated practice.



Adopted September 11, 1964, by the House of Delegates of the Medical and Chirurgical Faculty of Maryland. Also adopted by the Baltimore City Bar Association and the Maryland State Bar Association, 1964. Amended and Adopted by the Baltimore City Bar Association and the Maryland State Bar Association, July, 1966. Adopted as amended by the Medical and Chirurgical Faculty on September 9, 1967.

Medical Examinations and Reports

1. *Authorization of Patient Required:* A physician shall furnish to any person, any information concerning the history, physical condition, diagnosis or prognosis of the physician's patient only upon the signed authorization of the patient (or, in the case of a minor, of the minor's parent or guardian), or where authorized by law.*
2. *Reports to Patient or his Attorney:* The patient, or his attorney, upon written request, when accompanied by a signed authorization from the patient, shall be entitled to a prompt report from the attending physician, containing the history, physical condition, diagnosis, and prognosis, but need not include an evaluation of the disability in Workmen's Compensation Cases. The physician's fee for such a report should be commensurate with the time and effort devoted to its preparation.
3. *Request for Report:* When a medical report is requested of a physician, whether he be an attending physician, consulting physician, or examining physician, the lawyer requesting the report should make clear in his request the specific information desired; should disability evaluation and the prognosis be desired, the lawyer should so specify.
4. *Examination of Adverse Party:* Where there has been an examination of an adverse party, the examining physician shall not furnish to the person examined or his attorney or anyone else other than the person arranging for the examination a copy of his report or any information concerning his findings on such examination. The examining physician, acting for a party adverse to the person he is examining, should, where taking a medical history, attempt to elicit only such facts as are pertinent to his examination.
5. *Referrals by Attorneys:* Attorneys are cautioned not to refer a patient under treatment to another physician for examination, consultation or treatment without the knowledge of the physicians involved. The physician to whom the patient is referred may be guilty of a breach of ethics if he accepts a patient for examination, consultation or treatment without the knowledge of the treating physician.

* Examinations made in Workmen's Compensation Cases fall in this category.

Medical Testimony

1. *Conference Before Trial:* In order that the patient and client may have his case properly presented to the Court or other tribunal and to see that justice is done, it is the duty of each profession to present fairly and adequately the medical evidence in legal controversies. To arrive at that end pre-trial conference between the lawyer and the physician regarding medical testimony is encouraged and recommended. The members of each profession shall do their utmost to co-operate with the other in arranging a time and place satisfactory to both for such a meeting.
2. *Subpoena for Physician, Conference:* A subpoena should not be issued to any physician without prior notice and conference with such physician, where possible, concerning the matters regarding which he is to be interrogated, unless the physician and the lawyer agree that such conference is unnecessary.†
3. *Cooperation with Court:* It is recognized that the proper and efficient dispatch of the business of the courts cannot depend upon the convenience of litigants, the lawyers or the witnesses, including physicians who may be called to testify; both the lawyer and the physician should recognize, accept and discharge their obligation to aid and co-operate with the courts in the presentation of medical testimony.
4. *Arrangement for Court Appearance:* In arranging for the attendance of a physician at a trial or other legal proceeding, the lawyer should always have due regard and consideration for the professional demands upon the physician's time, and accordingly, the lawyer should, whenever possible, give the physician reasonable notice in advance of his intention to call the physician as a witness, and of the probable date on which the physician will be expected to testify.‡ The lawyer should also advise the physician to bring with him to court such records as the lawyer or the physician may need for the proper presentation of the

† Careful preparation of a case requires that the lawyer issue a subpoena for each important witness including physicians. A lawyer should explain to the physician that the issuance of a subpoena for the physician is in accordance with the standard practice of procuring physicians as witnesses.

‡ It must be understood that the lawyer does not control the date of trial in any case since this is a matter in the sole control of the court.

physician's testimony. Furthermore, during the course of the trial the lawyer should endeavor to keep the physician advised from time to time as to the approximate hour when he will be called to the witness stand; and upon the physician's appearance at the hearing at the hour agreed upon the lawyer should endeavor to arrange with the court for the prompt calling of the physician to the witness stand.

When arrangements are later cancelled for the court appearance and the physician has cancelled his regular appointments, he shall, nevertheless, be entitled to be paid a reasonable fee.

5. *Fees for Expert Testimony:* A reasonable expert witness fee is a proper and necessary item of expense in litigation involving medical questions. When a physician is called to testify as an expert witness he should be paid such expert witness fee as may be agreed upon between the physician and the lawyer calling him. In every instance in which the lawyer makes arrangements for expert testimony it shall be the duty of the lawyer to see that the physician is paid his fee.
6. *Contingent Fees:* Neither the physician called as a witness nor the lawyer so calling him shall invite or enter into any arrangement whereby the making of a charge for the physician's appearance as a witness or for the giving of testimony, or the amount of any such charge, shall be contingent on the outcome of the litigation or on the amount of damages awarded in the case.
7. *Physician Called as Witness:* The attorney and the physician should treat one another with dignity and respect in the courtroom. The physician should testify solely as to the medical facts in the case and should frankly state his medical opinion. He should never be an advocate and should realize that his testimony is intended to enlighten rather than to impress or prejudice the court or the jury.

   It is improper for the attorney to abuse a medical witness or to seek to influence his medical opinion. Established rules of evidence afford ample opportunity to test the qualifications, competence and credibility of a medical witness, and it is always improper and unnecessary for the attorney to embarrass or harass the physician.

Payment for Medical Services Rendered

Upon final disposition of any case wherein services rendered by a physician are involved, the lawyer shall forthwith notify the physician of such disposition and upon the receipt of the physician's bill and an order from the patient to pay the same direct to the physician, the attorney shall use every reasonable effort to see that the physician's bill is paid forthwith. The attorney shall make no charge to the physician for any services rendered in connection therewith. Unless otherwise agreed, the primary responsibility for payment of medical expenses rests with the client-patient.



Committee on Interprofessional Relationships

For many years the Medical and Chirurgical Faculty of the State of Maryland and the Maryland State and City of Baltimore Bar Associations, recognizing the need of a committee composed of both physicians and lawyers for the purpose of promoting a closer and more harmonious relationship between the two professions, have designated annually a group of physicians, now (12) twelve, to work with a corresponding number of lawyers (agreed upon and appointed jointly by the two Bar Associations).

The subcommittee on interprofessional relations of the said Joint Committee of 24, which subcommittee is composed of 4 physicians and 4 lawyers, who shall be designated by the chairmen of the respective groups and shall annually select its own chairman alternately from the medical members and the legal members; it shall consider all matters concerning interprofessional relationships between these two professions, including but not limited to the following:

1. Promotion and perpetuation of harmony between the professions.
2. Achieving a fuller understanding of mutual problems.
3. Consideration of legislation affecting medical-legal professional relationships.
4. Hearing of grievances stemming from interprofessional relationships.
5. Referral of grievances to the Medical and Chirurgical Faculty of the State of Maryland or the Bar Association concerned where that committee deems such reference warranted.

Physician/Patient Relationship

The legal profession recognizes that the practice of medicine is a hazardous task and that it is obviously not always possible for the physician to obtain a good result even with the best of attention and professional skill, and that an unfortunate result does not indicate in itself that the physician did not exercise the highest degree of skill and attention in the treatment of the case; and that a lawyer should not undertake to make any claim against a physician without thoroughly investigating the essential facts and details and being reasonably certain that if a harm has been done a patient, that it was due to genuine carelessness or negligence or lack of professional skill as distinguished from honest difference of opinion or the difference in honest judgment in a particular case. It should, nevertheless, also be considered that by the Canons of Professional Ethics the lawyer owes devotion to the interest of his client, warm zeal in the maintenance and defense of his rights, and the exertion of his utmost learning and ability, and that the client is entitled to the benefit of any and every remedy and defense that is authorized by law, and he may expect his lawyer to exert every such remedy or defense.

The medical profession recognizes that there are cases in which the patient suffers injury as a result of negligence, carelessness, or lack of professional skill on the part of a physician and that in these cases, there should be just compensation to the injured person. That in cases of this character, it is as much the duty of a physician-expert to assist the injured person as it is the duty of a physician-expert to defend a fellow-physician when he is proceeded against improperly.

General Provisions

Nothing contained in this Statement of Principles is intended to be inconsistent with the rules of law, Canons of Ethics of the local, state and national Bar Associations, and the Principles of Medical Ethics of the American Medical Association.

Physician/Pharmacist

Code of Cooperation

Preamble

Acknowledging that the practices of medicine and pharmacy need the combined services of both groups, this Code of Cooperation is hereby adopted as a declaration of principles of conduct for the two professions to follow. It is clearly understood that local laws, regulations and Codes of Ethics of both professions clearly take precedence over these principles of conduct.

It is the hope of the two professions that the adoption of this Code of Cooperation will result in an improved understanding and closer relationship between the professions of medicine and pharmacy in the interest of better health care.



Adopted by the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland and the Maryland Pharmaceutical Society's Executive Committee on October 12, 1967.

Physician

The American Medical Association's Code of Ethics states, in part:

"It is not unethical for a physician to prescribe or supply drugs, remedies or appliances as long as there is no exploitation of the patient."

Notwithstanding this statement, the Medical and Chirurgical Faculty of the State of Maryland believes that drug dispensing by physicians should be discouraged if adequate pharmaceutical service is available. A physician's professional source of income should be from the services he renders to his patients, and only from this source.

Physicians collectively, through the Medical and Chirurgical Faculty, recognize the following:

1. A patient should be permitted the free choice of his pharmacy, just as he should be permitted free choice of physician.
2. Physicians should not advise a patient as to the charge for professional pharmaceutical service.
3. The physician should cooperate with a pharmacist by specifying the number of times a prescription is to be refilled, and by making himself available to the pharmacist to determine whether or not his original orders should be altered after the original number of refllls has been obtained. A prescription should never be marked for a refill contrary to current laws or regulations.
4. Physicians may, at their own discretion, indicate on the prescription order they write, that the prescription label include the name of the drug ingredients, as well as any other information deemed necessary. This is an individual decision and one that will depend upon the expert judgment of the physician based on the patient as an individual. (House of Delegates, 5/64).
5. Physicians should not dispose of drug samples to pharmacists for any consideration, either direct or indirect. The use of drug samples in a physician's practice should be done in a manner that recognizes the position of the pharmacist in his role as a provider of drugs to the public. It is the responsibility of the physician to dispose of any undesired drug samples only through destruction, disposition to charitable organizations or through the approved program of the Woman's Auxiliary of the local medical societies. In no event should such drug samples be disposed of in a manner that would permit their falling into the hands of unauthorized persons.
6. Physicians should not enter into any rental, ownership or financial agreements or any other activity with pharmacists that would directly or indirectly affect the prescribing of medication by a physician in favor of a particular pharmacy or pharmacies.
7. The patient is always entitled to a written prescription. It is recognized, however, that it is permissible for a physician to prescribe by telephone to pharmacists of the patient's choice rather than writing prescriptions out individually.
8. Sale of drug samples either to patients or others, which have been given free to physicians, is to be condemned. In general, complimentary drugs should be used only as starter doses. (Council, 11/21/1961)
9. Mail order prescriptions are condemned, as this method of handling vital prescription matters would seem sharply at variance with the detailed, personal, professional care so essential to the safe distribution of prescription drugs. (House of Delegates, 9/14/62)
10. The use of prescription blanks imprinted with the name of a pharmacist, pharmacists or pharmacy is specifically prohibited by law.
11. Physicians are free to use either the generic or brand name in prescribing drugs for their patients. However, physicians should consult with the pharmacist as a member of the medical team in order to assure that the patient is properly served by being provided with medication of the highest quality.
12. Physicians should not write prescription orders in "code."
13. Physician's bills should include only those charges for professional services rendered by him or under his supervision.
14. When prescription blanks are not imprinted with a physician's name, his name and degree should be printed or typed legibly below his signature.

Pharmacist

Recognizing that pharmacists and physicians must work as a team, the pharmacists, through the Maryland Pharmaceutical Association—the state professional pharmaceutical society—hereby adopt the following principles: It is understood that the foregoing principles for physicians, insofar as they affect the profession of pharmacy are also subscribed to by the profession of pharmacy. It is also understood that some of these principles are presently incorporated in Federal and State laws and regulations as standards and requirements for pharmacy practice.

Pharmacy recognizes the inestimable value of the professional pharmacist to the health team, encourages him to fulfill completely the professional requirements of his calling, and desires that he decrease his activities in commercial enterprises which presently may be associated with but are not and should not be related to the practice of pharmacy.

1. Pharmacists, as well as physicians, are obligated to serve the public whenever their services are needed. On nights, Sundays and Holidays prescription services should be readily available in cases of emergency.
2. The pharmacist should never diagnose or prescribe, even at the insistence of the patient but should refer those needing medical attention to a physician of the patient's choice.
3. The sale of proprietary products and home remedies that have been approved by the Federal Food and Drug Administration for over-the-counter sale for self-medication shall not be considered counter prescribing by the pharmacist.
4. In an emergency, or preceding arrival of the physician, the pharmacist will render such emergency treatment as is indicated by his training, experience, scientific knowledge and good judgment.
5. If there is any question in the pharmacist's mind regarding the ingredients or labeling instructions of a prescription order, possible error, or safety of the drug, he should privately and tactfully consult the physician before making changes and never discuss it with, or in the presence of, the patient.
6. There should be no substitution of ingredients by the pharmacist, and he should follow the prescriber's directions in the refilling of prescription orders. If no refilling instructions are contained on the original prescription, the pharmacist should not, in accordance with law, refill such prescriptions without the authority of the prescriber.
7. The pharmacist should not discuss the composition of a prescription or its therapeutic effects with the patient except when in the best interest of the patient he finds it necessary to identify or differentiate medication. When such questions arise he should tactfully suggest that the prescriber is the proper person with whom such matters should be discussed.
8. The pharmacist shall be responsible for providing a comprehensive supply of drugs on which the physician may draw by prescription order for the treatment of his patient and serve as a source of information on new drugs and their combinations in order that the physician and his patient may have the advantage of the latest pharmaceutical developments.

General

Neither physicians nor pharmacists should approach each other with respect to the completion of illegal arrangements such as a pharmacist working as an employee of a physician. Pharmacists shall not engage in, and physicians shall not accept, advertising of a pharmacy in a physician's office or waiting room.

The physician has a responsibility to make clear to the patient that even though a specific drug may be expensive, it is the best therapeutic agent he feels can be administered in treating the condition of the patient. Pharmacists, in turn, should not comment on the efficacy of the drug prescribed or of a substitute drug.

Publicity in connection with professional activities of either pharmacists or physicians should be cleared through the appropriate professional group. In all cases, news or feature stories affecting both professions should be developed cooperatively by the two groups.

Addition: The Council of the Medical and Chirurgical Faculty of the State of Maryland at its September 7, 1967 meeting voted to adopt the following recommendation:

Approved the policy that prescription blanks printed for physicians after January 1, 1968, *not* contain *printed* information indicating refills.

Statement on Report on Protocol on Registered Nurse Responsibilities and Duties as Related to the Medical Practice Act

A major concern of nurses and of the professional nursing organization is related to the professional and legal scope of their practice in the administration of medications and treatments prescribed by a licensed physician or dentist (the dependent area of nursing function).

The American Nurses' Association has encouraged liaison activities between state nurses' associations and state medical societies to study problems occurring within the dependent area of nursing function in order to arrive at joint policy statements on any procedures under question. The American Medical Association has encouraged such liaison activities. In June, 1965, a Nursing Liaison Subcommittee of the Liaison Committee of the Medical and Chirurgical Faculty of the State of Maryland became formal.

The Report on Protocol on Registered Nurse Responsibilities and Duties as Related to Medical Practice Act is the outgrowth of a survey of practices within the dependent area of nursing function conducted by an Ad Hoc Committee of the Maryland Nurses' Association and the Hospital Council of Maryland in conjunction with the Maryland Nurses Association Committee on Professional Nursing Practice in 1964. This brief report, of course, does not cover all areas of dependent function in nursing.

The Maryland Nurses' Association views the report as constituting guidelines for further definition and policy development within individual institutions and agencies. It is implicit 1) that the registered nurse performing these acts shall have received formal theoretical instruction and supervised clinical practice and shall have demonstrated proficiency in performance satisfactory to the medical and nursing staffs: 2) that she act under *written* orders of a licensed physician or dentist; and 3) that she act under *written* policies established by medical, administrative, and nursing staffs.

Although the physician, hospital, or agency assumes responsibility for acts delegated to the nurse, she must always be aware that she is still responsible for her own acts.

Registered Nurse Responsibilities and Duties

as Related to Medical Practice Act

Preamble

Discussion took place on procedures now performed by nurses and the desirability of their being in scope of practice of medicine and still being practiced by registered nurses, under the order of a licensed, registered physician who assumes full responsibility for the act. Specific permissions and restrictions may be made by the local medical staff in each hospital in the state. Generally, if the act performed by the registered nurse is basically mechanical, not requiring the exercise of medical judgment, and is done by order of or supervision by a physician, it is legal.

The following suggestions were made on the items listed, provided by the Maryland Nurses Association:



Report on Protocol on Registered Nurse Responsibilities and Duties as Related to Medical Practice was adopted by the Executive Committee of the Board of Directors of the Maryland Nurses Association on July 23, 1965, with the addendum contained in the statement on the preceding page. Adopted by the Council June 17, 1965.

1. *Initiation of external cardiopulmonary resuscitation and artificial respiration [mouth-to-mouth or mouth-to-nose]*: This would be done as a first-aid measure, and any person adequately trained and accepted as qualified to do it would normally proceed with such action. Nurses should have a training program for the persons who perform this service. They should also be taught protective measures in training to prevent contracting a disease such as tuberculosis, syphilis or meningitis.

2. *Administration of investigational drugs:* This would be done on orders of a physician, with permission of the patient (consent form), and approval of the medical advisory committee or board at the hospital.

3. *Administration of subcutaneous infusions*: Approved administration by nurse, with orders of a physician.

4. *Vena puncture*: Approved administration by nurse, with orders of a physician.

5. *Administration of intravenous a) Fluids, b) Blood, c) Medications, d) Medications added to fluids:*

(a, c) The procedure and specific fluid must be ordered in writing and signed by a licensed physician.

Wherever the professional Registered Nurse is working, the medical, nursing and administrative staffs should establish written policies which clearly and specifically state the conditions under which the professional Registered Nurse may administer intravenous fluids.*

The following shall be included in the written policies:

- The specific requirement for instruction and supervised practice. A requirement that the
- Administration of intravenous fluids and medications by professional Registered Nurses be performed under medical supervision.
- A requirement that a current roster of nurses who have had sufficient supervised practice and instruction and who have demonstrated satisfactory ability to perform the procedure be included.
- A current list of specific solutions which a professional Registered Nurse may administer and of specific drugs which he or she may add to the solution. This list should be reviewed and revised at designated intervals.
- Provision of continuing in-service education.

(b, d) The above policies should apply to transfusions of whole blood and/or blood derivatives. In those situations where whole blood or blood derivatives must be administered by a nurse, it is imperative that the nurse work directly under medical supervision, *preferably the hospital Pathologist or physician who has been appointed in charge of the Blood Bank.*

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*Approved by the Executive Committee on February 22, 1966.

Explanation of Terms

Supervised practice and instruction: It is not feasible to construct one specific instructional pattern for use in the many and varied existing agencies. Instruction should be based on a formal course which teaches the principles of intravenous therapy and provides enough supervised practice to insure the development of sufficient skill for safe performance of the procedure.

Professional Registered Nurse: A graduate of a professional school of nursing, currently registered by the Maryland State Board of Examiners of Nurses.

Intravenous Administration: Introduction into a vein where the procedure involves vena puncture by needle but does not involve incision into or incision to reach a vein.

Medical Supervision: A physician is immediately available.

6. *Removal of inter-cath (indwelling intravenous catheter):* Approved administration by nurse.

7. *Deep intratracheal suction*: No, should be anesthesiologist, or anesthetist under the direction of anesthesiologist.

8. *Administration of anesthesia during labor:* No, should be anesthesiologist, or anesthetist under the direction of anesthesiologist.

9. *Vaginal examination during labor:* Approved on order of physician.

10. *Rectal examination during labor:* Approved on order of physician.

11. *Removal of sutures:* Approved on order of physician.

12. *Suture of minor lacerations:* No—unqualified.

13. *Exchange fluids in peritoneal dialysis:* Qualified—yes.

14. *Performance of tracheotomy:* No—unqualified.

15. *Insertion of gastric tubes:* Approved.

16. *"Milking" chest tubes to keep them open:* Approved.

17. *Interpretation of electrocardiograms:* No—unqualified.

18. *Substitute for the pharmacist in his absence:* The night nurse supervisor is authorized to utilize the services of the pharmacy under the following conditions *

*Adopted February 15, 1966 by Liaison Committee of the Medical and Chirurgical Faculty of Maryland.

a. The pharmacist must provide an emergency pharmaceutical kit containing drugs necessary for the peculiar or particular needs of the hospital from the time the pharmacist leaves the hospital until he returns.

b. An appropriate record shall be kept in the pharmacy which the nurse shall sign, showing the name of the drug withdrawn, the exact amount of each dose, and the total amount of each drug withdrawn.

c. For any drug not included in the emergency pharmaceutical kit, the pharmacist should be called and should provide emergency service in the procurement and the dispensing of the drug required.

19. *Application of pressure bandages to control hemorrhage:* Approved.

10. *Operation of intermittent positive pressure machine:* Approved, if properly trained.

21. *Care of the patient with cardiovascular diseases in coronary care or intensive care units:* The Med-Chi Faculty and Maryland Nurses' Association recognize the propriety of registered nurses using monitoring, defibrillating and resuscitative equipment. In addition, under certain conditions it is appropriate for registered nurses to institute life-saving corrective measures—if the licensed physician is not immediately available and if all other conditions below are adhered to: *

- The Registered Nurse must have had a special and intensive course of instruction in the above techniques and have the knowledge necessary for her to perform these duties safely.
- Registered Nurses may be allowed to perform these procedures in line with policies carefully stated and voted on by the medical group responsible for the care of patients in the specific hospital.
- These techniques should be carried out only by licensed professional nurses who are working in Coronary Care Units or an Intensive Care Units.
- Only nurses who have demonstrated that they are capable of performing these tasks may be designated to do so.

*Adopted by the Council of the Medical and Chirurgical Faculty of Maryland on June 8, 1967.



Laboratory Services

On May 28, 1964, the Liaison Committee established the Laboratory Services Subcommittee to "consider laboratory services as they related to the general public health and requirements of the people of Maryland."

Three meetings of the subcommittee have been held and a letter addressed to all state health departments in the United States, asking for information with respect to the operation of clinical laboratories in their state. The response to the query was very gratifying but, in general, most states seemed to have little regulation except for serology tests. In view of this the subcommittee was of the opinion that it must develop its own ideas in this area. (Adopted by the Council, June 17, 1965.)



Guides for Ethical Conduct

The Subcommittee feels that with the full cooperation of the medical profession and others concerned, a program can be maintained in Maryland obviating the need for legislation to enforce rules which basically call for ethical conduct. The medical profession has guides for the development of such a program in the *Opinions and Reports of the Judicial Council of the American Medical Association*. The tenets of this document, subscribed to by all medical societies in the United States, basically point out that an unearned addition to a fee for a laboratory test constitutes an unethical practice and further suggest that direct billing by all who render service is the most desirable method.

The first recommendation of the Subcommittee is that all component societies of the Faculty thoroughly review the aforementioned document, that such a review be held in a regular meeting of the medical societies for all members.

Clinical Laboratories

It is recognized that clinical laboratories both in and out of Maryland perform tests for Maryland patients. It is the feeling of the Subcommittee that adequate supervision by competently trained individuals is necessary in every laboratory.

The best interests of the patient are uppermost in the physician's mind; therefore, the laboratories best equipped, both with personnel and equipment, should be used to perform the tests needed. The necessity for the highest quality of work in performing laboratory tests is without question. It is the feeling of the subcommittee that all physicians should assure themselves that the tests being performed for their patients meet the highest standards. By education of the medical profession and other disciplines involved, it is felt that any laboratories now doing substandard work would be forced to meet the demands of the public by providing higher quality work.

Laboratories in Physicians' Offices

The subcommittee recognizes that certain physicians maintain laboratories in their offices for the convenience of their patients. This statement in no way reflects negatively on this practice. These laboratories should maintain the same high quality of performance, and the recommendations are equally applicable to them as to all physicians.

Education

It is the recommendation of this subcommittee that all disciplines concerned with this matter establish a program of education of its members regarding an ethical program based on the tenets of the *Opinions and Reports of the Judicial Council of the American Medical Association,* which interprets in detail the *Principles of Medical Ethics of the AMA.*

Such a program should include the material contained in this subcommittee report which supplements to a certain degree these Principles.

Billing

A contractual agreement between the laboratory and the physician is not in the best interests of the patient. The absence of a contract will eliminate the possibility of a conflict of interest for the physician. In addition, such an agreement makes it difficult, if not impossible, to conform to the principles of direct billing, since a true cost cannot be determined for a specific test under a contract which allows a sliding scale of fees depending on the volume of tests performed.

Conclusions

In order that the highest standards of work be performed in clinical laboratories in Maryland and that the highest quality of laboratory services be made available to the citizens of Maryland, the subcommittee recommends that the following guidelines be established.

1. Laboratory medicine is the Practice of Medicine and should be practiced only in laboratories owned (except in licensed hospitals and governmental facilities), operated, and professionally adequately supervised by licensed and registered physicians.
2. It shall be considered proper for a physician to send to any other physician of his choosing an announcement that he has opened an office, changed the location of an office or changed the professional composition of his office for the practice of medicine, in the format approved by the Medical and Chirurgical Faculty. Return forms that serve only to facilitate the communication between the interested physician and laboratory but do not in themselves give specific information, such as fees, office hours, special qualifications, other than membership in professional Board or Societies, are acceptable. Fee schedules and other specific information material may be sent only to those physicians who request them or who *regularly utilize* the facilities of the laboratory.
3. It shall be considered unethical for:
   (a) A lay employee, directly or indirectly, to solicit work from physicians.
   (b) To advertise laboratory services in any media such as magazines, journals, newspapers, etc.
   (c) To display any advertising material on vehicles.
   (d) To distribute mailing containers except on request.
4. Whenever any physician collects fees for laboratory services which are not performed by him or his regularly employed assistants, the opportunity exists for him to split the fees and to receive income to which he is not entitled; therefore, all billing should be done by the laboratory billing the service. If a clinician and a laboratory share the responsibility for a laboratory procedure, each should send a bill for services rendered. No physician should be denied a reasonable fee for obtaining a specimen for testing purposes and/or interpreting the results of the test, but this should be itemized separately and appear on the physician's statement.
5. It shall be considered unethical for any physician to:
   (a) Submit specimens to any laboratories not owned (except in licensed hospitals and governmental facilities), operated and professionally adequately supervised by a licensed and registered physician.
   (b) Bill for laboratory services not performed by him or his regularly supervised employed assistants.
   (c) Send specimens to any laboratory rendering laboratory services at a flat fee (so-called contractual agreements).

(d) Share income from laboratory services directly or indirectly with any lay person.
(e) Offer laboratory services under a fictitious name.
(f) Offer laboratory services for the care of patients as a corporate structure.
(g) Have a financial interest in any clinical laboratory where the physician is not personally and professionally responsible for the quality of the work performed in the laboratory.
(h) Collect fees from any insurance company for laboratory services not performed by him or his regularly employed assistants.

6. The subcommittee also recommends that, with the approval of the Liaison Committee, these recommendations involving the question of professional ethics should be submitted to the Faculty's Mediation Committee for endorsement and approval and final submission to the Council for its approval as Faculty policy.

The Nature of Blood Banking

From the selection and bleeding of a donor to the administration of his blood as a transfusion, the two main pertinent processes comprise: (1) blood banking—obtaining the blood and its storage, processing, and issue; and (2) transfusion service—its selection, preparation for, and administration to an individual person. These two processes may occur either in close proximity both in time and place, or at great distances in place, variable but limited separation in time. This report takes into consideration, primarily, the first of these processes, blood banking. Blood banks are of three general classifications: hospitals, community, and commercial.

Professional Medical Interest and Responsibility

The attending physician holds uppermost in mind the welfare of his patient. Individually, it is impossible for him to take precautions that blood transfused on his orders is reasonably safe from harming the patient. These precautions can be undertaken through the collective expression of professional ethics incumbent upon his fellow physicians. This concept involves a series of professional responsibilities. The potential harmful effects of transfused blood are so varied that the selection of donors and all subsequent steps must be retained under ethical, medical professional supervision. It is on the basis of these considerations that professional associations have issued statements of policies and principles as follows:

1. American Association of Blood Banks Standards for a Blood Transfusion Service, Fourth Edition, 1964
   (a) All phases of the selection of blood donors and of the collection, storage, processing and transfusion of blood shall be the responsibility of a qualified, licensed physician with a thorough knowledge of blood bank methods and of transfusion principles and practices.
2. College of American Pathologists, 1964 Directory
   Statement of Principles Relating to the Practice of Pathology
   (a) Whereas, The Practice of Pathology is defined as pathologic anatomy and clinical pathology, including such subdivisions as clinical chemistry, clinical microbiology, hematology, diagnostic radioisotopes, exfoliative cytology, blood banking, clinical microscopy, and other related disciplines, and
   (b) Whereas, Pathology is recognized as the practice of medicine by statutes of various states, courts of law, and organizations such as the American Medical Association and the College of American Pathologists . . . Therefore be it
   (c) *Resolved,* That contracts or agreements between pathologists and institutions must be in accord with the requirements of law and with the codes of ethics and statements of principles of the American Medical Association and of the College of American Pathologists; and be it further
   (d) *Resolved,* That such contracts or agreements must preclude the sale of the services of a pathologist by institutions, organizations or nonmedical persons, for a fee; . . .
3. American Medical Association, Judicial Council Opinions and Reports, 1964. Section 6.

RELATION OF PHYSICIANS AND HOSPITALS

"A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the service of that physician by such agency for a fee . . ."

Practical Considerations

The quantities of blood required for transfusion have greatly increased in recent years because of the development of techniques for surgery of the heart, blood vessels, and respiratory organs, the care of acute injuries, and for other therapeutic purposes. Increased knowledge of the hazards of tranfusion have tended to limit the use of transfused blood, but further knowledge in this field and its dissemination and application are needed. Nevertheless, demands for increased amounts of blood for transfusion are expected. To meet these demands, if the medical profession should take the attitude that blood for transfusion is a commodity rather than a professional service, commercial enterprises can be expected to undertake, as has already been started, the procurement and banking of blood as a profit-making endeavor. Unless ethical, medical supervision can be maintained over all aspects of blood banking, the reliance by attending physicians on blood for transfusion is unsound. Therefore, your committee believes that every blood bank of any type must operate only under full authority of an ethical, licensed physician, who is, thereby, professionally responsible. The arrangements for his remuneration should be such as to preclude his providing medical services for the profit of a non-medical agency.

Conclusions

In order to attain optimum standards of medical care, your subcommittee recommends the adoption of the following principles:

1. The practice of blood banking constitutes the practice of medicine requiring full supervisory authority and responsibility of a licensed physician.
2. Any physician who allows his name and professional status to be used by a noncommercial blood banking agency without first assuring himself that he has full professional authority over the operations of the agency, and without actually assuming the professional responsibility for the products of the agency, is to be considered an unethical practice until it is otherwise demonstrated.
3. It shall be unethical for a physician to allow his name and professional status to be used by or receive remuneration from any blood bank operated primarily as a commercial enterprise.
4. All licensed and registered physicians, particularly members of the Medical and Chirurgical Faculty of the State of Maryland, should encourage and support ethical agencies for the provision of blood for transfusion, in order to guide, under medical supervision rather than commercial or non-medical supervision, the provision of the amounts of blood necessary for proper medical care.

Use of Terms Medical Center or Medical Clinic

The committee was of the opinion that the terms *medical center* and *medical clinic* bring a wide difference of opinion as to their meaning. In the instance of the term *medical center,* it felt that this was of no real significance and that no formal action was necessary insofar as designation of what constitutes a medical center.

The use of the term *medical clinic* also brought forth a wide divergence of opinion as to its meaning. The committee, therefore, is of the opinion that some definition should be provided to members of the Faculty for their guidance. The committee recommends that the definition of *medical clinic* as defined by the AMA be used and that this use be disseminated to the Faculty members for their information. This definition is as follows:

Diagnostic Clinic

The name "clinic," because of its association with the earlier uses of the term, implies a very superior service by very superior individuals. This is frequently not the case. If the American Medical Association is to define a diagnostic clinic, it must be done in a way that will represent the efficiency that modern scientific progress has made possible to the doctor of medicine who has kept abreast of that progress and the idealism or ethical principles that for hundreds of years have been our most cherished heritage as a profession. The Council submits the following as its opinion of a proper definition of a diagnostic clinic:

1. A diagnostic clinic is an organization of physicians whose sole work in the clinic is to make or supervise diagnostic examinations of patients referred to the clinic by doctors of medicine, or to collaborate in general diagnostic surveys.
2. The reports of the diagnostic clinic on examinations and tests are made only to the referring physician unless he requests that the case and the recommendations for treatment be discussed with the patient as a part of a professional consultation at which time the relationship of the results of the diagnostic studies to the general condition of the patient is open for discussion. In such case, discussion is only by a member of the staff.
3. The staff of the diagnostic clinic should include representatives from all the specialties that are of recognized diagnostic usefulness. Every clinical examination, laboratory test or X-ray procedure is made by a physician who specializes in that field or under his supervision. The clinic must be equipped to allow the various specialists to exercise fully their abilities.
4. The control of the clinic must be vested in one or more members of the professional staff. Any profits are to be apportioned only to the members of the staff actually engaged in the work of the clinic. There must be no dividends, bonuses or salaries paid any individual except for services rendered.
5. The clinic must be governed in its activities by the same ethical principles as apply to any individual member of the American Medical Association.

It is recognized that under this definition only in cities large enough to support the various specialists needed can a diagnostic clinic be established or maintained. Unless the specialists are available it is not a diagnostic clinic worthy of the name. (AMA House of Delegates, 1939)

From report of the Policy and Planning Committee. Adopted by the Council, June 17, 1965.

Modification of AMA Specialty Listings for use in Yellow Pages of the Telephone Directory

Policy on Telephone Directory Listings As Approved By Council, November 16, 1967.

Recognizing that a single, statewide policy should be in existence with respect to physician listings in the "yellow pages" or classified telephone directory listings, because many telephone books cross over political subdivision lines, the Mediation Committee recommends adoption of the following policy:

1. Listings shall be made under the heading Physicians and Surgeons. It is understood that where a physician has a specialty that warrants listing under another heading, this is permissible (such as Clinical Laboratories).
2. Listings may include the following ONLY:
   name, address and phone number; office hours; an "if no answer" number; "physicians" or "surgeons" home address and telephone number;
3. Listings may be made ONLY as follows:
   practice limited to ..... (Using only those specialties approved by the American Medical Association or as modified and approved by a special liaison group to be named by the Faculty to work with the C & P Telephone Company)
4. Listings must be uniform in size and type face
5. Display or box advertisements are strictly prohibited
6. Listings may not be carried in a telephone directory where a physician does not have an office or residence, except in combined area directories where a listing may be published in all three yellow page directories, viz., Washington, Maryland Suburban, Virginia Suburban, Baltimore City, Baltimore Suburban West, Baltimore Suburban East.
7. It is preferable for physicians to list the letters "MD" following their name rather than the title "Dr." preceding their name, inasmuch as this leaves no doubt that the person listed is a medical doctor. At times, other types of "Doctorates" can be listed in error.
8. Where multiple offices of a physician are listed, each office listing MAY NOT be preceded by the words "Physicians Office." The same applies to any other category of listing that might arise.
9. The Medical and Chirurgical Faculty may list, in the Metropolitan Baltimore area, a telephone number where the public may call to receive assistance in selecting a physician.
10. Items 2, 3, 4, 6, and 7 apply also to telephone directory listings in the White pages.

* * * *

1. Substitution of following words, rather than those shown in AMA Specialty Listing:
   (a) Diagnostic Radiology rather than Diagnostic Roentgenology
   (b) Ear, Nose and Throat rather than Otolaryngology
   (c) Eye, Ear, Nose and Throat rather than Otorhinolaryngology
   (d) Proctology, rather than "Colon and Rectal Surgery"
   (e) Separation of specialties, "Obstetrics" and "Gynecology," if the physician wishes to pursue only one of these areas
   (f) Eye rather than Ophthalmology
2. Physicians may use only one specialty and may not state items such as "General Medicine and Cardiovascular," "Internal Medicine and Gastroenterology," "Internal Medicine and Endocrinology"
3. Clarification on use of expressions such as:
   (a) Rosedale Medical Group
   (b) Perry Hall Medical Center
   (c) Central Medical Center
   (d) Franklintown Medical Center
   (e) Industrial Accident Clinic

PROFESSIONALISM

There is great emphasis on professionalism today. Professional status is sought after; professional people constitute a growing proportion of the labor force; and an impressive percentage of the gross national product is devoted to the training of professionals.

In spite of this emphasis on professionalism and the common usage of the term, there is no universally acceptable definition. The essential characteristics of the professions are poorly known by the general public. The research on the nature and functions of the professions in modern society has resulted primarily from the efforts of the sociologists. Yet, even among sociologists theoretical and methodological consensus is not yet so great that there is any absolute agreement on the definition of the professions.

Traditionally, there have been three recognized professions: medicine, law and theology. All three are characterized as occupations having the service of man as a goal. The attraction of the three has been not the love of the reward that can be gained in terms of material acquisitions; but rather, the altruistic goal of service to others.

There are certain essential attributes of professions on which general agreement ordinarily is possible. The more important of these are: the obligation to study and acquire knowledge in order to engage in the practice of the profession; primary orientation to the community interest rather than to individual self-interest; a high degree of self-discipline standardized through codes of ethics voluntarily adopted and enforced by the professional group itself; and a system of rewards signifying work achievement and thus a goal in itself, rather than a means to some end of individual interest.

Medicine has been characterized as the queen of the professions. In medicine, personal judgment in the application of technical competence is required to a high degree, since the information at the physician's disposal must be applied to individual cases, each of which differs in some respect from all other cases. The profession of medicine carries a high responsibility which cannot be fulfilled without specialized education. And yet, academic achievement is not sufficient as a guarantee of professional competence. Licensure is required in addition.

Medicine traditionally has had two principal means by which to guarantee to the public that it is performing its function. The first is strengthening the great graduate centers of education which are the sources of research and teaching. The second is strengthening the professional association and its internal disciplinary procedures against all forms of less-than-professional practice. The trend now has the vast majority of American physicians embracing the thesis that by being their professional brother's keeper they are keeping their art pure and holy.

There are many pressures on physicians as professionals today. Rapid changes in contemporary society through technological developments have complicated the physician's life. New knowledge is being accumulated so rapidly that no individual physician can keep up with the entire field of medicine. Patterns of urbanization and mobility resulting from technological advances further complicate his life. The number of people to be helped requires different practice arrangements and new economic patterns change the opportunity for profit. Standards of professional behavior appropriate a century ago tend to become outdated.



Homo Medicus Americanus

JAMES HOWARD MEANS

The character which the doctor of medicine has assumed in the United States today is the subject of our inquiry. The behavior pattern of any profession does not develop overnight; it takes time to evolve. Its characteristics and configuration are formed by its environment and its heritage, as are those of a species in the course of its evolution.

To understand fully the doctor in the United States today, we must know something of his past. How did he get to be the way he is? He and his medicine, of course, came first from Europe. Medicine of the 16th and 17th centuries was rather medieval in character. Authoritarian since the time of Hippocrates (460-377 B. C.), it had finally run into scholasticism and intellectual stagnation. In addition, it had probably declined somewhat in quality in the process of exportation from the Old to the New Worlds. It is unlikely that those doctors who were well established in the Old World would have left their comfortable practices to settle in an unknown wilderness.

Those intrepid medical souls who did venture to cross a dangerous ocean and invade a hostile continent, accompanying other pioneers and settling where they pleased, probably were distributed fairly adequately with respect to need. In New England, at least, some of these men were members of the Puritan clergy who, having resolved to migrate to America, took the precaution of also obtaining a medical education before embarking, thus equipping themselves to care for the bodies as well as the souls of their flocks in the wilderness. All of these doctors had their heritage of Old World medicine to guide them, but what had that to offer them in their new circumstances? Some elementary knowledge of anatomy, physiology and materia medica, a bag of drugs and a few technical gadgets of one sort or another were their equipment. Their method of practice was highly empirical. They purged, they puked, they sweat and they bled, especially the last, all on the basis of tradition rather than of experience or of scientifically proven fact. Their drugs were chiefly medicinal herbs, generically called "simples," which they also used in accordance with accepted custom. They could do very little for their patients beyond relieving certain symptoms and bestowing comfort and moral support.

In the early days, the colonies were swept by one deadly epidemic after another, all imported, in the face of which the doctors were helpless: smallpox, measles—very deadly in those days—scarlet fever, plague, typhus, diphtheria and many others. These epidemics at least left behind a considerable number of immune survivors, whose presence in the community tended to slow up the rate of spread in subsequent epidemics. Until 1800, when vaccination to prevent smallpox was introduced by Dr. Benjamin Waterhouse, who got his vaccine directly from Edward Jenner, there was no specific way of controlling these pestilences. However, attempts to block their importation by the establishment of quarantines at the ports began as early as 1648. These restrictions were perforce imposed by government, and thus we may say that the principle of governmental responsibility for the safeguarding of health was established.

European-trained doctors of medicine were few and far between in the early settlements, and as the population in the new country expanded, they became in short supply. It is said that between 1620 and 1650 about 25,000 English settlers arrived in New England, after which they largely stopped coming. Probably the doctors stopped as well as the rest, yet the population doubled every

25 years from its own growth potential. For a continuing supply of doctors the colonists were obliged to train their own by the apprentice system or to send some of their young men of promise to Europe to obtain proper medical education in the great centers of learning. Increasing numbers of the more gifted and privileged of these students followed the latter course, or perhaps a combination of both courses—first an apprenticeship at home followed by a visit abroad for truly learned instruction, or vice versa. This pattern continued to be followed until well into the 19th century. To walk the wards of the great European hospitals afforded an opportunity to see and learn about all manner of diseases and the treatment thereof, a practical clinical* experience obtainable at that time nowhere else in the world.

With the arrival of the 18th century, progress in American medicine became more perceptible. Practitioners of considerable distinction began to appear, most of them, but not all, located in the larger cities and towns. The wars which beset America in the 18th century called forth a flock of surgeons to attend the wounded and thus gave great impetus to surgery in America.

American medicine, however, could not have survived indefinitely on the momentum imparted by Europe. It had to develop its own medical institutions on this side of the Atlantic before a truly indigenous medical profession could come into being. Medical schools were the prime necessity, for without them no physicians or surgeons could be adequately qualified. The first of these was established in Philadelphia by the University of Pennsylvania in 1765; in New York City, King's College (later Columbia University) founded one in 1767. Harvard University founded a medical school in Cambridge, Massachusetts, in 1783, and the College of Philadelphia did likewise in Philadelphia, Pennsylvania, in 1790. Dartmouth College started a two-year school in Hanover, New Hampshire, in 1798, and Yale University started its medical school in 1813 in New Haven, Connecticut.

* The words "clinic" and "clinical" can be confusing to the nonmedical person. Derived from the Greek word meaning "bed," they came to be applied to a patient in a bed, and finally to anything having to do with patients whether in bed or out of it. Thus "clinical" means having to do with patients, and "clinic" denotes a place where patients are cared for. We speak of clinical medicine to mean practical medicine—diagnosis and treatment of patients—in contrast, for example, to laboratory medicine or public health medicine.

But medical schools alone, in which instruction is given largely by lectures, are far from sufficient for the education of good practical physicians and surgeons. Hippocrates himself insisted that the training of the physician should be primarily through personal observation of patients. It is in hospitals that patients can be had for teaching purposes in the greatest abundance and variety. In the English colonies in North America, no hospital was available for such a purpose until the Pennsylvania Hospital in Philadelphia, of which Benjamin Franklin was one of the founders, opened its doors in 1756.* A teaching hospital was set up in New York (the New York Hospital) in 1791, and another in Boston (the Massachusetts General Hospital) in 1821. These were the first of the so-called voluntary hospitals in the United States, and with their establishment American medical education can be said to have been launched.

In a learned profession, if it is to remain learned, there must be free interchange of ideas among its members. All knowledge must be shared. Agencies for the discussion of professional knowledge beyond the medical school level become indispensable. The facilities needed to meet these requirements are chiefly medical societies, medical journals and medical libraries. In the latter part of the 18th century, there was a great burgeoning of medical societies in North America—state societies, county societies and societies for various local and special types of medicine. These societies were where doctors gathered to exchange experiences, to argue things out with one another. They provided a form of intellectual sharpening which Sir William Osler called "brain dusting"—not to be confused with the present-day term "brain washing"—without which the attainment of professional excellence is impossible. Doctors took to it with avidity and gusto.

Finally in 1848 a national medical society emerged, which was the creation of a congress called together for that purpose by the Medical Society of the State of New York. All medical societies and schools of medicine in the country were invited to send delegates. This national body took the form of a superstructure federating the

* Both French and Latin American colonies were ahead of us in establishing hospitals. For example, Cortez founded a hospital in Mexico City in 1524, and the Hotel Dieu was founded in Montreal in 1644.

state medical societies, and chose the name of American Medical Association—the AMA. The original intent was that it should be democratic in character, patterned somewhat after the nation itself.

In the beginning the AMA's avowed purpose was "to initiate reforms to correct the deplorable condition of medical education which then prevailed." Its establishment was a very important event in the history of American medicine, for it was the beginning of "organized medicine," so-called, and it made the American doctor an organization man. We cannot, therefore, understand him without knowing something of his societies, which determine much of his behavior. They have made him a conformist and a conservative to a considerable extent. Through the years, the AMA has gained steadily in political power. It has learned that through collective action it can exert great political pressure effectively to further the ends favored by its leadership. It has become oligarchic rather than democratic in character.

The establishment of native medical schools and teaching hospitals inevitably had a profound effect upon the nature and quality of American medicine and on the direction and speed of its progress. In the beginning the schools were flimsy affairs and a very far cry from the multimillion-dollar university medical centers of today. They were nonetheless their precursors. The facts that these schools required faculties, and that these needs for the most part be trained in Europe, provided a strong stimulus to the improvement of medical scholarship in the United States. A great many of these early professors were actually trained in Edinburgh, some in London, and a bit later, many in Paris.

The 19th century saw many scientific discoveries and technological advances in the practice of medicine. It was the time, especially in France, of the great clinicians. It also saw the beginnings of our principal preclinical sciences of today—physiology, biochemistry, histology, pathology, bacteriology, immunology and pharmacology. These subjects, which constitute the usual first and second year subjects of the modern American medical school, had their initial greatest effulgence in Germany, and also to a considerable degree in Britain. Even the United States at this time had its William Beaumont, a great pioneer in the physiology of digestion. Also, although there has been much controversy as to who discovered ether anesthesia, no one can contradict the fact that it was an American contribution. About this time another discovery was made by an American doctor, that by Oliver Wendell Holmes of the infectious nature of puerperal or childbed fever. Thus the United States began to contribute on its own account to the progress of scientific medicine and was no longer solely dependent on Europe for advancement in the basic sciences.

The last two decades of the 19th century were the time in American medicine when the great clinicians were paramount. In the United States they reached their ascendency before the medical scientists reached theirs. It was also a time when the private practitioner was in his glory. The vast majority of doctors of medicine in the United States in the 19th century and into the 20th derived their livelihoods exclusively from fees received from private patients for services rendered. They became segregated into categories in accordance with their aptitudes and preferences. In rural areas there were the country doctors, who were general practitioners and family doctors. They had immense self-reliance and would undertake to do nearly anything. When they ran into problems they could not handle, they called in consultation doctors better equipped than they were themselves. The education of these men was usually inadequate. To a considerable extent they got their training on the job, in their own practices. Many of them were products of proprietary medical schools, of which there were many in the 19th century. The faculties of these proprietary schools were practitioners who voluntarily banded together, called themselves a faculty, offered instruction consisting largely of lectures, and financed the affair by the tuition fees they collected.

These general practitioners and family doctors worked hard and developed wonderfully good relations with their patients and families of patients. They made endless house calls, day or night, driving long distances over the countryside in their horse-drawn vehicles, and saw many patients in their offices, which were usually located in their own homes. When patients required bed care, the doctor usually looked after them in their homes. Only rarely did he send them

to a hospital, of which there were very few. Such care, if rather primitive medically, was a humane service of inestimable value. The doctor's availability gave the patient a feeling of confidence and security which is by no means always to be had today.

In urban areas the situation was similar, but on a somewhat more exalted level. The doctors, again almost entirely in private practice, were for the most part unspecialized, but it was during the mid-19th century that specialization began to appear. To get training in a clinical specialty one was practically obliged to study abroad, preferably in Vienna. Then one came home, hung up the certificate of his specialty training in his waiting room, and went to work on much the same basis as the general practitioners, except that much more of the work would be done in the office than in the home. It was from all these practitioners that the faculties of medicine in the clinical subjects were recruited.

Those physicians and surgeons in each field who had the most acclaim in their communities, who were most highly thought of by their fellows, and who had had the most distinguished educations were likely to be made professors and chiefs of service in hospitals. These doctors were usually unpaid. They were happy to serve for nothing on the staffs of the teaching hospitals because of the acclaim to be gained and because of the experience in both the care of patients and the teaching of students which was to be had there. These great clinicians became the idols of the medical students. To walk through a hospital ward in the wake of such a one was as stimulating an experience as they could have. Much of the diagnostic technology of today was still undreamed of. Far more dependence was placed on direct observation, history taking and physical examination than today. The teacher who could discover a great deal about the patient and his disease by the power of his own unaided senses was greatly revered.

One very important difference between those days and today lay in the matter of hospital care for private patients. The great voluntary hospitals and the municipal and county hospitals did not ordinarily admit to their wards the wealthy or well-to-do. If the doctor wanted to hospitalize a private patient and care for him himself, he had to send him to a private hospital of one sort or another, and these were few and far between before 1900. But he was not likely to seek hospitalization if he could possibly manage in the patient's home. With the much greater availability of good private-duty nurses in those days, this was usually possible. Surgeons did even major surgery in homes, usually on the kitchen table. I can recall vividly how in 1897 my younger brother was cared for quite successfully in our home through typhoid fever with two relapses. Everything that was available in a hospital was made available at home.

With the arrival of the automobile, the practicing medical profession very rapidly became motorized and it was possible for physicians to cover much wider areas than their horse-drawn predecessors. Surgeons often traveled through several counties in a morning, doing three or four major operations at widely scattered points and instructing the local family doctor on subsequent treatment. One of Boston's leading surgeons in my boyhood lived a few doors away from where my family did. Often I saw them taking off early on a winter's morning in a huge open touring car. Surgeon, chauffeur, assistants, nurse, and maybe a medical student or two, all in great coonskin coats, made a very impressive sight.

But even this sort of care was on the way out. Gone are the days when the doctor went to the patient. Now the patient usually must go to the doctor. In those days, too, there were consulting physicians who would answer calls by motor up to 100 miles or so. In some cases such work constituted the major part of a doctor's practice. The memory of this style of practice remains vivid in the minds of some people, who long for its return. Doctors who remember this era may also regret that today's civilization no longer permits them to practice in this manner.

Such briefly is the background and evolutionary heritage of the American doctor of today. We must now investigate what use he is making of his inheritance. Before doing that, however, let us take note of three momentous events which stirred American medicine around the turn of the present century.

The first of these was the opening of The Johns Hopkins Hospital in 1889, in which four men played vital roles. There was Mr. Johns Hopkins himself, who had the vision of a new kind of higher education for the United States and who gave the money to found a university to

implement it. Next was Dr. John Shaw Billings, who planned and built The Johns Hopkins Hospital and participated in the selection of its staff. The third, William Henry Welch, was selected by the university's President Daniel Coit Gilman—who in turn had been proposed for The Johns Hopkins presidency by President Charles William Eliot of Harvard University—to be the first professor of pathology. Welch had been thoroughly trained in Germany at the time when the basic scientific disciplines were blossoming in almost explosive fashion. France had had its Claude Bernard and Louis Pasteur, but it was in Germany that scientific medicine had its first most vigorous growth. Welch was thoroughly cognizant of this new knowledge and transplanted it to Baltimore for the benefit of American medicine.

The fourth, William Osler, who came to Baltimore from Canada via Philadelphia to be the first medical chief at Hopkins, revolutionized the clinical training of the medical student. He got him to the bedside and gave him a responsible role under guidance in the care of the patient, as Robert Graves had done in Dublin a half century earlier. This system of teaching, which Osler imported from Britain, represented a great advance in clinical instruction in the United States. Indeed, what Osler and Welch accomplished between them was the fusion of Germany's best in basic medical science with Britain's best in clinical teaching. The blend was better than the sum of the ingredients, and it constituted an uplifting force in American medical education which has been felt ever since.

The second of the great events which I mentioned was the founding in 1903 of the Rockefeller Institute for Medical Research. The chief significance of this event was that it pointed up the facts that without research there is no progress, and that effective research requires specially skilled people abundantly supported in all their basic needs, scientific and otherwise. It was a first step in the chain of events, continuing to the present time, which led to the stupendous expansion of medical research facilities and activities which we see all about us today, and which constitute a large segment of the total medical establishment.

Finally, the third event, the publication of the Flexner Report in 1910, rocked medical education in the United States to its roots. Abraham Flexner, an educator and a brother of the famous Dr. Simon Flexner, made for the Carnegie Foundation for the Advancement of Teaching a survey beginning in 1908 of nearly every medical school in the United States. His findings were shocking. Nearly everywhere he found grossly inadequate teaching facilities. Faculties "consisted of busy practitioners with no time for teaching and no thought of research." This reminds us of the purpose avowed by the AMA in 1848, "to initiate reforms to correct the deplorable condition of medical education which then prevailed." It still prevailed apparently at the beginning of the 20th century. Nor had the claim of the first AMA president that "the medical profession always cleans its own house" been substantiated. After the publication of the Flexner Report many medical schools were closed and many others were reformed and upgraded to meet certain set standards. The only school which Flexner found completely satisfactory was at The Johns Hopkins University.

Full-time university medicine came into being because of the drawing realization that the teaching of medicine required as much pedagogic skill as the teaching of anything else at the university level. It could not be left to amateurs. The fact that a doctor was a superb clinician did not imply that he was *ipso facto* a competent teacher nor that he had the requisite ability to organize and administer the various activities of a teaching clinic in a way to make them effective. For some years before the clinicians, the basic science members of the medical faculties had been on a full-time salaried basis. Osler, perhaps earlier and more clearly than anyone else, perceived the necessity that there be on faculties of medicine a certain number of salaried teaching clinicians. As early as 1911 he wrote: "The professor [that is to say of a clinical subject] has three duties—to see that patients are well treated, to investigate disease, and to teach students and nurses. He should be a man of wide sympathies and of trinocular vision. He should have a comprehensive and thoroughly scientific training, and should enter clinical medicine through one of three portals—physiology, chemistry, or bacteriology and pathology. He must be keenly practical, keenly scientific, fond of his patients, fond of his work, and devoted to his students. He should live as much in his wards and laboratories as do his [preclinical] colleagues in their laboratories of anatomy, physiology, or physics." How one finds such

paragons has become the number-one question for faculties of medicine today.*

With Osler this kind of medicine began germinating, and after the Flexner Report, its growth and spread through the United States were greatly accelerated. An educational revolution it truly was, and its effects have been felt by nearly all of our present day medical doctors. Although relatively few of them have gone into full-time university medicine themselves, at least most of them will at some point in their education have come under the influence of full-time clinical teachers who will have left some mark on them. They will be better educated than they otherwise would have been, and they will have a broader understanding of the nature of medicine, in consequence, than did their predecessors.

SINCE the last war, there has been, also, a growing public interest in health matters engendered by innumerable articles on health in newspapers and periodicals, and in advertising of the drug industry. All this printed matter has created in the people a greater concern about their health than had ever entered their minds before. In consequence they have developed notions about how they should be treated, and sometimes they have even told their doctors what to do for them.

Very often in the early antibiotic days, a patient entered a doctor's office and said, "I have a cold, doc, and I want a shot of penicillin." If the doctor refused to give it, the patient went off and found another doctor who would. This sort of thing is detrimental to the doctor-patient relationship, which to be good requires confidence on the part of the patient in the doctor. With irritation on both sides, the gap between doctor and patient is widened. There are other factors which tend to widen this gap. For one thing, so much of the diagnostic process is now done through technological procedures that the doctor has lost some of his apparent omniscience, prestige and mystique. For another, along with the development of the affluent society and the increasing demand for medical services, the incomes of doctors and people in allied professions and occupations have risen to incredibly high levels, which did not drop off much even in the depression years, thus causing some resentment among people who were having financial difficulties, often very severe.

The most conspicuous change in the behavior of the doctor is that nowadays he is usually in such a hurry that he is less accessible and less communicative. This also widens the gap. He is usually in a hurry because he is overworked: Too many people need medical care, people demand more medical care; and there are not enough doctors to supply it. The doctor is busier than he wants to be or than is good for him. I also suspect that at times his devotion to his patients is lessened and the quality of medical care which he provides is impaired. Moreover, owing to the advance of medical science and technology, the care he is expected to supply becomes ever more complicated. A greatly increased burden of work is thrown upon him. No wonder he is in a hurry. He is desperately trying to catch up, and despite the longest working hours of any of the professions, he can never quite do it. This is veritably a doctor's dilemma. Will the doctor inevitably have to confine himself to strictly medical matters, or can he continue to be the family friend and counselor?

An outstanding example of a corner cut is the disappearance of the home visit, especially the night call, which has been supplanted by the telephone. Something essential can be lost when the home visit is not made. Seeing the patient in a relaxed and leisurely manner in his customary setting and in contact with his family can be very important to the doctor in developing a complete understanding of the case. In the old days the doctor was the intimate friend of the family, almost a member of it. He was the family counselor for all sorts of things other than medical.

ACTUALLY, under present-day working conditions in medical practice, home visits have become so difficult for the doctor that he cannot be blamed very much for not wanting to make them. If he has a waiting room full of patients eager to be seen and very likely there by appointment, or if he is conducting a ward round or holding a clinic in a hospital, how can he rush off to pay a home visit? Traffic jams and parking difficulties are also inimical to house visiting. Another change in today's way of life which impairs the quality and continuity of medical care is the greatly increased moving about of individuals and families. Continuity of care becomes difficult—sometimes impossible.

One of the greatest responsibilities of the prac-

* See W. Osler, "The Hospital Unit in University Work," Lancet 1191, i, 211.

titioner of medicine is to be available to his patients. As time goes on, this he is less and less likely to be. He will accept, for example, the care of a patient with a prolonged illness for whom curative medicine has nothing to offer, but who for psychological reasons needs frequently to be visited. The doctor may get more and more irked by having to make such visits; he regards them as a waste of his precious time, which he would rather spend on patients he thinks he can help specifically. The element of compassion ceases to count very much. Of course, there is a solution for a problem of this nature. The doctor can, and should, withdraw from the case and turn it over to another doctor who is competent and willing to accept full responsibility in his place. The official code of medical ethics prescribes just such a procedure.

Our doctor's professional forebears of the 19th century, and earlier, practiced medicine in a serenely individualistic and leisurely manner, not permitted by our present society. Now the doctor is inevitably part of a great social structure which we may call "American medicine," or the "health forces of the nation." In these forces the doctor of medicine, together with his counterparts in public health, may be said to constitute the top echelon. He is also surrounded by, and dependent upon, a host of other professional people known as paramedical—nurses, social workers, therapists of many kinds, administrators and technicians of endless variety. Without access to this great array of skills, our doctor could not make available to serve sick people the vast stockpile of medical knowledge which exists. Nor can the doctor who does have access to them utilize them for the people's benefit without organization for medical care.

There are other evidences of a declining sense of responsibility among doctors. For example, we have recently seen doctors walking out on strike, quite like labor union members, in Saskatchewan, and threatening to do so in New Jersey. This would have been unthinkable a few decades ago. The increasing willingness to practice medicine by telephone and the custom of giving patients appointments weeks in advance, during which time their illness may become seriously aggravated, seems to me to fall short of the ideal doctor-patient relationship. The growing gap between patient and doctor should give the profession some uneasiness.

Another feature which characterizes the medical practice of today is the great increase in specialists. Nearly everyone in medicine nowadays seems to wish to be a specialist. Even the most bona fide generalist* will find some little area in which he seeks to acquire some touch of authority or expertise. Specialization is favored by doctors because it is easier to know a great deal about a little than the reverse. The specialist, moreover, makes a better income and enjoys a somewhat higher status in the public mind. It is interesting and perhaps significant that figures show that the abler medical graduates prefer to go into specialties. It is generally the scholastically lower-standing men who go into general practice.

In medicine the diseases of most of the organs or systems of the body are regarded as fit subjects for specialization: neurology, hematology, gastroenterology, dermatology, ophthalmology, as well as many others. Sometimes a specialty is built up around a technology, such as radiology and endoscopy—of course, surgery actually is in this group. These are clinical specialties, the older of which are now being further split up into splinter specialties. To practice any of them exclusively and with expert skill, the doctor must first have become a well trained general physician or surgeon, and upon these qualifications superimpose his training as a specialist. In order that the public can be assured that a doctor is a properly qualified specialist, a flock of so-called specialty boards has been established to define training requirements and conduct examinations which, if passed, permit the doctor to be declared a certified specialist in his particular field. These boards are voluntary, not official; nevertheless, they have with the passage of time acquired sufficient prestige so that their accreditation is as good as official. A specialty may be said to have reached full maturity when it gets its board. This process can easily be carried *ad absurdum*.

It is not usually best that patients go directly to specialists since they may choose the wrong ones.

* By generalist, I mean that which is left of the general practitioner of an earlier day, the opposite of the specialist. He is a nonspecialized physician with a broad spectrum of competence. He is the one to whom the patient ideally goes first and who very likely becomes the patient's regular personal physician. His first duty is to make a diagnosis and then secure for the patient whatever treatment this diagnosis calls for. Usually nowadays he is an "internist." This classification is essentially confusing and useful only to indicate the kind of training the doctor has had.

Their generalist should refer them to appropriate specialists. Sometimes patients engage in what we call medical shopping; that is to say, they make their own list of specialists on the basis of information picked up by hearsay.

Consultative activities have also changed a great deal within my memory. In the Victorian spirit, the consultation used to be a formal affair. If the attending physician reached an impasse, he asked to be allowed a consultation; or if the family were concerned about his capacity to deal with the case, they could ask for one. Under these circumstances the ethical code required that the attending physician call in a consultant. Consultations, then, were personal meetings; a date was set and the doctors—sometimes several of them had been called—gathered at the bedside. After observing the patient as much as they liked, they adjourned until they had arrived at a consensus of opinion. Now the attending physician refers the patient to such specialists as he deems necessary, and the patient must go to all their offices to see them. In due course he goes back to his personal physician, who will have heard from the several consultants and digested their separate opinions to form a final one of his own, on the basis of which he instructs the patient, or should instruct the patient.

It has seemed to me that in recent years, doctors have become increasingly reluctant to call for consultations, especially in smaller towns and rural areas. One reason given is that they wish to save their patients expense, but a more likely reason is that they fear some loss of face if they ask frequently for consultations. They fear the implication may be drawn that they lack professional self-confidence or skill; they may be fearful of losing a patient to a consultant or of having the embarrassment of being proven wrong.

In similar fashion many doctors seem to be reluctant to call in paramedical people, such as social workers, visiting nurses or occupational therapists, when they could render important benefits to patients. Doctors even seem to be ignorant of what resources of this kind are available in their communities, or how to call them into action.

The ethical standards of the doctor today form an essential part of our characterization of him. Have they been maintained at the highest level ever achieved by the profession, or have they deteriorated? The code of ethics to which the profession has at least given lip service through some 23 centuries is embodied in the Oath of Hippocrates. It is completely valid and appropriate today, but there are certain very urgent ethical problems which bedevil the modern doctor about which the Oath gives but limited help. The most important of these are birth control and euthanasia. It is for society, not for the medical profession, to solve both of these problems. Both birth control and euthanasia involve the taking of human life and are therefore repugnant, but the former need not do so. It may rest upon measures designed merely to prevent conception, not to abort life already started. I believe that the problem it poses will be solved by society as soon as population density gets so high that the people living at the time can no longer tolerate it.

Euthanasia by definition involves the taking of life, but nowadays it often takes the form of merely permitting nature to end life for us. The questions may well be asked: How long are we justified in prolonging life by artificial means in the person who has no prospect of recovery? Are we justified in curing pneumonia with penicillin in the old or chronically ill person who has nothing but a life of misery to look forward to? How long are we obligated to maintain life by mechanical artificial respiration when there is evidently no chance whatever of the patient's being able to live without it? May we turn it off and let nature take its course? The humane answer would seem to be yes, but we have, inadvertently, trained our young doctors to consider it a virtue to prolong life for the sole purpose of prolonging it.

Thou shalt not kill but needst not strive
Officiously to keep alive.*

It is necessary that we consider how doctors behave when organized as well as how they act as individuals. The founding of the AMA in 1848, which to all intents and purposes was the beginning of so-called organized medicine in the United States, has already been mentioned. In seeking to identify the role played by organized medicine in the progress of medicine in the United States, it will best serve our purpose to consider the whole establishment of national, state and county medical societies as constituting, from the sociological and political points of view, a single great apparatus. This is organized medicine or the doctors'

* Arthur Hugh Clough, "The Latest Decalogue."

guild. Its ideology is very like that of the big labor unions. It is out to improve medical education and medical care, but in its own way; and it has done much to accomplish these ends. But what it does is always done in such a way that the best interests of the doctors are never contravented. Thus in 115 years the AMA has stood steadfastly against any extension of government participation in medical affairs. "Keep the government out of medicine," is its primary slogan. To that end it has spent huge sums of money on lobbying and propagandizing the public and on other pressurizing tactics, and it has now set up a continuing political action committee quite like those of the fighting labor unions. Every attempt that has been made by liberally minded groups to improve medical care and make it more accessible—and there have been a succession of such attempts since 1932—the AMA has attacked with ever increasing truculence.

When organized groups become truculent, it is usually because they feel threatened or insecure in some way. Just how do the organized doctors feel threatened? Presumably they are fearful that any further extension of government into medicine (we already have considerable) would sabotage certain prerequisites of practice which they cherish or would diminish their power in the community. They wish to be the sole arbiters of their own professional affairs. They wish to maintain a monopoly in medical practice. They forget perhaps that medicine is for the people, not for the doctors. They need some enlightenment on this point.

Not only is the doctor of today under constant pressure from his guild to conform to its tenets and ideology, but also various other socio-economic forces peculiar to our times bear down upon him and condition his behavior to some degree.

One very characteristic problem of the doctor today is the constant and growing pressure that he is under from the drug industry. Of course, our whole society during most of its waking hours is under constant bombardment by Madison Avenue through all the mass media, but the technique used with the general public is a bit different. In the case of the doctor, it includes a daily deluge of advertising material by mail, invitations to try out new drugs on unsuspecting patients, and free samples left by detail men on the doctor's desk. The effort is to make the doctor "beholden" to a drug company and thus oblige him to prescribe its products. And consider the increasing amount of iatrogenic disease—disease produced by the doctor. Many of the new drugs can produce very serious untoward side effects, which are worse from the patient's point of view than the malady for the treatment of which they were prescribed. One of my teachers once said, very wisely, "Gentlemen, in the practice of medicine, for God's sake at least do as little harm as possible."

And now one may ask what is to be done to make the situation better. If the primary trouble is the shortage of medical manpower, more effective recruitment would seem to be one way. Medicine must be made to appear more attractive to our young people seeking professional careers, for it requires the longest and most difficult of all professional education programs in the United States today. It is especially arduous for married couples, among whom it sometimes creates very difficult emotional problems. The wives of medical students and house staff members are left alone a great deal, so long are their husbands' hours of work. Medical education is also the most costly. The situation is much worse in these respects than it was a decade or so ago. And to cap it all, there is the threat of military service always in the background.

A good suggestion for increasing recruitment of medical personnel is to entice more women into medicine. Some countries, notably Russia, have a very much higher percentage of women in medicine than we do. From my own experience in this matter, which goes back at least to the middle twenties, when we began taking women interns and residents on the medical services of the Massachusetts General Hospital, I have formed the opinion that women are as capable of becoming fine physicians as are men, and that we should welcome as many well qualified ones as we can get. If these recruitment difficulties could be overcome, and a great increase in medical enrollment should result, then we would be short of teachers and of teaching facilities. To many educators and others it seems that these difficulties can only be overcome by government aid, but organized medicine always has and may be counted on to continue to oppose such aid.

Another important way in which medical care can be made more available is through increased

efficiency in the use of the doctor's time by organization for medical care. Since one doctor can himself no longer provide all a patient may need, doctors will have to work in well integrated groups in which the various members play individual roles, the sum of which will add up to a good medical care program—group practice. Group medicine is, actually, the multiple representative of the single practitioner of earlier days. There is nothing particularly new in the concept of group medicine or group practice. Every hospital with a closed visiting staff and an organized house staff is, in effect, practicing group medicine. There is nothing particularly new in the concept interest in group medicine, and a steadily increasing proportion of doctors in the country are practicing as members of organized groups. There is now even a national society working vigorously to promote group health plans (G.H.A.A., or Group Health Association of America). The existing groups run all the way from small ones with less than 20 doctors to great chains of such facilities as in the Health Insurance Plan of Greater New York or Permanente in California. The Mayo Clinic is certainly a group medical unit of a sort.

In group practice at its best, the doctors are paid by salary, and patients pay for services on prepayment plans of some sort. As such medical groups proliferate and especially as they become arranged in chains and networks, they well may be expected to cover the country and afford what amounts to a national health program on a private enterprise basis. Under the challenge of group practice, the presently prevailing system of solo practice for a fee for service may be expected in time to disappear, to be replaced by the prepayment group system. Under these circumstances a given number of doctors should be able to bring better medicine to more people than under the present system. Then indeed we could have prepaid comprehensive medical care for all, which this writer would regard as the ideal.

Such then in very broad outline is a representation of the practitioner of medicine in the United States today. Whether he likes it or not he is inevitably a functional unit in a vast network of services which collectively have the overall function of preserving, promoting and restoring the health of the American people. He is a very far cry from his horse and buggy professional ancestor, but it is very surprising that he is not as aware of this fact as he ought to be. He clings to that rugged individualism of the colonial doctors. As indicated earlier, he is very well organized for political action, both at the national and at local levels; he has his own professional politics conducted within the framework of the medical societies, often by professional medical politicians. But within the realm of providing medical care, which after all is his *raison d'etre,* the doctor is hardly organized at all. For the most part he is hostile to organization at this level; he calls it socialized medicine if and when government has any part in it, and he may even occasionally brand private efforts to achieve the purpose "socialized medicine." The public should be aware of this animus.*

In conclusion, we can say that the doctor of today is hard pressed from many points of view. He is to a considerable degree a harassed person. He is engulfed by a deluge of new scientific knowledge, which his conscience tells him he is obligated to grasp and apply to his patients' betterment, but which his education has not prepared him always to understand easily. He finds in a sorry state of chaos the organizational machinery which is necessary to make the medical care he can provide easily available to any or all people, and finds very little good will or intent to set it aright. If he tries to find a better way by experiment, he is chastised by his powerful union. He is under constant pressure to conform. While the total professional work load is increasing, he sees a steadily increasing number of his fellow professionals being siphoned off into research or other full-time medical occupations and thus rendered unavailable to help him meet the total medical care problem. He has every right to feel frustrated, but the amazing thing is that he rarely, if ever, shows any outward or visible evidence of it.

Thus the functions and character of *Homo medicus americanus* are extraordinarily diverse and far flung. Yet the basic principles of Hippocrates still apply to them all, and bind them together into one great profession.

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* For a good description of group practice and what it has to offer the patient, see E. P. Dearing, "The Challenge of Comprehensive Health Care," *American Journal of Public Health* (1962), p. 2071.

Medical Discipline

The Medical Disciplinary Committee, through its various activities, sought to find out if satisfactory disciplinary mechanisms exist and if they are being effectively used. The results of the study show that, by and large, adequate medical disciplinary mechanisms do exist and that they are used. The frequency and effectiveness of their use, however, are less impressive. There has been a failure, in some areas, to act promptly, impartially, and objectively when the necessity arises.

Based on the belief that there is room for improvement in the discharge of medicine's disciplinary obligations and the realization that disciplinary mechanisms must be constantly reviewed and improved, the committee recommends the following:

Medical Associations

Your committee believes that state medical associations have not been as effective as they could be in the area of medical discipline because of the practice of limiting their concern to matters that are appealed to them from the local level. Some defects in basic mechanisms and considerable apathy at the county and state level in taking action against offenders have contributed to the situation which exists.

It is the recommendation of your committee, therefore, that:

1. State medical associations become actively concerned with the disciplinary programs of county medical societies and develop a greater interest in and knowledge of the activities of their component societies in the discharge of disciplinary obligations;
2. State medical associations review their disciplinary programs critically and at once to the end that changes in disciplinary mechanisms at state or local level may be made as necessary;
3. State medical associations develop indoctrination programs for use by their component societies to acquaint new members with ethical principles and acceptable socio-economic practices;
4. State medical associations continue to encourage the widest development and use of grievance committees and urge that their component societies make the services of such grievance committees more widely available;
5. State medical associations increase their concern and activities with respect to complaints of overcharging, medical advertising and solicitation of patients, abuse of prepayment and insurance mechanisms, as well as all other conduct inimical to the best interest of the public and the profession;
6. State and county medical societies utilize grievance committees as "grand juries" to initiate action against an offender so as to obviate the necessity of making an individual member of a medical society complain against a fellow member;
7. State medical associations amend their bylaws to provide that the state association

Conclusions and recommendations in the report of the Medical Disciplinary Committee to the Board of Trustees, American Medical Association, June, 1961.

may take necessary disciplinary action when it believes that serious violations of ethical principles have occurred without necessary corrective action being taken first at local level or when the state association believes that serious charges brought against an individual are not being given proper or prompt consideration by the disciplinary committee of the county medical society concerned;

8. Each state medical association and all doctors within the state give increased support to the state board of medical examiners as it seeks to obtain proper appropriations for the conduct of its affairs and that the state medical association and its membership be concerned with the selection of qualified and dedicated members for its state board of medical examiners;
9. Each state medical association develop and administer review and utilization committees; and
10. County medical societies review their by-law provisions relating to disciplinary procedures and revise them as necessary.

American Medical Association

Your committee believes that the American Medical Association should become more aggressive and active in supplying advice and assistance to state boards of medical examiners and state and county medical societies in all aspects of medical discipline. It is recommended, therefore, that:

1. The Executive Vice President be requested to provide this assistance, on request, through the proper department of the Association;
2. The American Medical Association, in cooperation with the Federation of State Medical Boards, the Council of State Governments, and other interested groups draft a model medical practice act;
3. The American Medical Association encourage and urge each state medical association to report annually to the American Medical Association all major disciplinary actions taken within its jurisdiction during the preceding calendar year;
4. The American Medical Association encourage and urge the Federation of State Medical Boards to cooperate with it in developing a means whereby each state board will report promptly all major disciplinary actions taken by it to the American Medical Association;
5. The American Medical Association distribute annually to all senior medical students in the United States copies of the Principles of Medical Ethics and Opinions and Reports of the Judicial Council;
6. The American Medical Association prepare a syllabus or lecture guide on the subjects of medical ethics, medical practice acts, and proper socio-economic conduct for the use of physicians called upon to give lectures on these subjects in medical schools, hospitals, or before medical societies;
7. The bylaws of the American Medical Association be changed to confer original jurisdiction on the Association to suspend or revoke the AMA membership of a physician guilty of a violation of the Principles of Medical Ethics or the ethical policy of the American Medical Association regardless of whether action has been taken against him at local level;
8. The American Medical Association request that adequate lectures on ethics and proper socio-economic practices be given in all hospitals approved for internship or residency training; and
9. The American Medical Association instruct its representatives to the Joint Commission on Accreditation of Hospitals to urge the Joint Commission to adopt, as a requirement for accreditation, the giving of adequate lectures on ethics and proper socio-economic practices each year within the hospital.

Finally, your committee recommends that American medicine at the national, state, and local level maintain an active, aggressive, and continuing interest in medical disciplinary matters so that, by a demonstration of good faith, medicine will be permitted to continue to discipline its own members when necessary.

The Physician as a Defendant in Discipline

THE HONORABLE CHARLES L. TERRY, JR.
Judge, Superior Court of the State of Delaware

One of the most delicate subjects with which a doctor can be confronted is the imposition of discipline upon his fellow practitioner.

It would be a clear impertinence on the basis of a law profession to presume to define those limits beyond which a doctor could not go without incurring disciplinary sanctions, or to propose just what those sanctions should be in each instance of an infraction. Such a task, if it can be done at all, could best be done by you, and you have always had a just call to the responsibility it imposes.

The ill-informed and misguided are always in our midst and the lunatic fringe seemingly has a never ending supply of novel and dangerous schemes by which they seek to cure all of the real and imaginary ills of society. The advocation of socialized medicine might well be viewed by you in just such a light.

When the hue and cry goes out for such an extreme program you can rest assured that you, as the potential victims, have failed somewhere along the line. To be dangerous, such a proposal needs considerable popular support, and if such support can be marshaled, then there must be something not altogether right in the status quo.

Presented at Annual Meeting of Federation of State Medical Boards, Chicago, February 6, 1962.

The law profession has often felt the bite of this type of discontent, and when the legislative axe had fallen we were forced to admit that we had become too complacent, too jealous of our presumed prerogatives, and even too contemptuous of outside criticism. The area of procedural reform is the area where we became most vulnerable. Cumbersome and stilted court procedures surviving from hoary antiquity were blindly preserved to the disgrace of the profession and the frustration of justice.

When the profession failed to move, the legislatures did, and the result was often an unwholesome hodgepodge. In Delaware, the legal profession recognized the danger before it was too late, and effected its own reform. The result was most salutary. A little more delay and it might have been tragic. This analogy may not be perfect but it should illustrate the point.

One often hears petty digs and sly innuendoes leveled at various members of the medical profession and at the profession in general. Ill-founded? Perhaps. But does it matter? It should not be ignored, rather it should be feared, and it should prompt introspection, analysis and action, otherwise the public concept is distorted. The criticism continues and grows. The stature of the profession is being eroded—piecemeal.

If the thesis has any validity, if there is an undercurrent of criticism and discontent, and if it can be traced to various acts of individual practitioners, then the most obvious corrective device is the disciplinary process.

First of all, as a judge, I believe I know something of the problems that confront men when they sit in judgment of their fellow men; when they try to dispense that illusive essence called justice. To that end I have spent the better part of my adult life. But I also know something about the peculiarities of enforcing the strictures of medical discipline. This last bit of insight I have gathered from sitting on the Medical Council of Delaware. By law, my position as President Judge of the Superior Court requires me to serve in the company of two physicians as a member of that three-man board. Among other things, we are charged with the enforcement of medical discipline, and more than any other body in our State we are faced with these problems in their varying complexities.

It should always be foremost in our thoughts, that when we enforce discipline upon an errant physician we sit in a judicial capacity and we punish the doctor in much the same fashion as criminal courts punish a malefactor. To suspend a license for a specified time or to revoke it altogether is close to being the most harsh punishment you could wish to inflict on a doctor. Even the lesser disciplines such as probation or reprimand might seriously affect a man's reputation and practice. Because the charges and consequences are often so severe, we must exert every effort to be scrupulously fair in our procedure.

As a Judge, this procedural question is one of the paramount considerations in disciplinary cases. The whole action is quasi-criminal in its scope and effect. A man stands charged with unprofessional, unethical or dishonorable conduct. He may lose his entire livelihood if he is convicted. Therefore, he must be guaranteed every possible device to defend himself in these most crucial proceedings. The procedural rules being the rules by which he is tried, if they be anything less than fair his trial can only be a mockery and justice will be subverted.

In Delaware we have a very up-to-date Medical Practice Act, and we have incorporated in that Act various rules of procedure which are well calculated to provide all the desired safeguards. If you should wish more information, refer to the Act itself, particularly Title 24 of the Delaware Code, Section 1741.

The main thing to be considered in such procedural schemes is that they must have full and ample provisions for the receipt of all the evidence, fair and impartial evaluation thereof, adequate review, and the right of appeal.

In Delaware there are provisions for a three-man censor committee in each County, composed of physicians recommended by the County Medical Society, and appointed by the State Medical Council. Anyone may present charges to the committee, or the committee may act on its own motion. Once the possibility of misconduct is presented to the committee the procedures for notice, hearing and determination are activated. The alleged offender is notified of the charges and the date and place of hearing. He has the right to be represented by counsel and the charges are presented to the committee by the Attorney General who represents the prosecution throughout all the proceedings up to final conclusion.

Both sides have full privileges to subpoena witnesses and documents and to take depositions. Thus we are assured of a complete production of evidence and a craftsmanlike presentation. A stenographic transcript is prepared. After all the evidence is in, the committee of physicians makes its evaluation and in a draft report sets forth findings of fact and conclusions. The respondent is given a copy of the report and he has an adequate time in which to file all of his objections. The committee considers his objections and then files a final report with the Medical Council with a recommendation as to whether or not discipline is justified. The doctor also gets a copy of this report. And once again he is entitled to file exceptions, this time to the Medical Council. The Council then receives briefs and hears arguments. Only after all of these opportunities have been offered does the Council sit to determine what action should be taken. It may revoke or suspend a license, place the offender on probation, censor him in some other fashion or acquit him as it sees fit. Two doctors and a judge make this decision. If the offender is still not satisfied he may appeal the matter to the Superior Court where he can have a full review of all the foregoing proceedings on the

record as prepared. Once more there are briefs and arguments. The Superior Court has the power to remand the case for further hearings before the Medical Council or it may reverse, affirm or modify the decision from below.

All of the major safeguards are included in this procedure. Full notice, right to counsel, right to production of all evidence, right to subpoena, right to examination of all witnesses, right to be judged by competent judges from among ones "peers," right to appeal, right to review. No more could be asked.

Our law, however, does not provide for closed hearings. This might be a weakness, for if a man is acquitted he may still suffer from the publicity of trial. Perhaps all of the proceedings should be confidential until such time as a final judgment was entered and all available redress exhausted. Then if the decision were adverse it should be widely published, not only in the offender's home state, but throughout the land. I suggest that a national clearing house be established, by some group like the AMA, to collect the results of disciplinary actions everywhere, making its files available to all who might wish to determine that a particular doctor does not have a record of ethical or professional infractions.

So much for procedure. But let me observe that all of the procedure that we can adopt means not one thing if the law is not fair or is not enforced.

Many times a doctor does something to cause adverse comment, but no one calls him to task. Why? This reluctance often stems from an uncertainty of just what the standards are, an uncertainty as to whether or not the doctor has really done something wrong. This uncertainty coupled with a natural aversion to "blow the whistle" conspires to let many abuses which really deserve attention, go by the board. This is fertile ground for the public malcontent which has been discussed. Without well-defined standards, enforcement is retarded. But what is equally important, enforcement without adequate standards is productive of injustice.

In the criminal law punishment is imposed for the violation of the law. But there must be a law or standard upon which we can determine a breach. The law must be reasonably specific; it must be published. If it is vague and indefinite as not to give reasonable notice of what it proscribes, it would be unjust and unconstitutional to enforce it. The standard of precision required often varies with the nature of the offense, and where this is true of the criminal law it would seem to be equally true in the field of professional ethics. Because of this, there is a real need to formulate a relatively comprehensive and specific code of professional ethics for the practice of medicine.

The Delaware Medical Practice Act gives the medical council a broad base upon which to mete out discipline. There are 12 enumerated areas in which we are empowered to act. In 11 of the 12 the grounds are adequate. Hence, there is little difficulty in understanding what was meant by such offenses as "conviction of a felony, including an unlawful abortion," or "drug addiction or chronic and persistent addiction to intoxicants to such a degree as to render the licensee unsafe or unfit to practice medicine," or "the practice of medicine under a false or assumed name." These are fairly clear-cut offenses. But what precisely do we mean by saying it shall be improper to engage in "any dishonorable, unethical or unprofessional conduct likely to deceive, defraud or harm the public?"

With most of the more flagrant violations of good ethics or good practice we would have little trouble. For example, the indiscriminate writing of prescriptions for narcotics so as to enable an addict to keep up his source of supply, is such an offense as would prompt anyone to consider revocation. This and other such clearcut areas of misconduct are recognized by all physicians. They are the black zones. But what of the gray zones? When does a doctor disgrace his profession by too much social drinking? How much, if any, restrictions are desirable in such an area? Certainly we would be foolish to try and specify the number of drinks a doctor could take in a public cocktail lounge, but if his carousing becomes a source of gossip, does not the entire profession suffer to some degree? And if so, should he be admonished by some agency with authority to do so?

The field of professional ethics and practice is continually shifting with the mores of our time and the advance of medical science. Such national organizations as the American Medical Association and the Federation of State Medical Boards should continually re-examine and revise a code of ethics such as would provide physicians throughout the country with readily understood and generally accepted standards by which they should conduct themselves. Such standards should

be continually re-examined and, to be effective, should be generally circulated.

The key here, however, is the word "general." No nationally accepted standards can solve all specific questions, nor should they be expected to. In most instances such codes would merely give expression to conduct generally recognized as the norm.

Once such general standards have been formulated and published, then the particularities can be determined in a variety of ways. One obvious way would be to charge an errant practitioner with a particular violation under a general and broadly worded canon, and then try him before the appropriate tribunal to ascertain whether or not the alleged offense is truly within the ambit of the general standards as interpreted by the tribunal.

Another way would be to have the local medical societies add their own embroidery to the general standards. Furthermore, various societies of specialists might also find the need for spelling out certain particular standards for their brother specialists, which might not otherwise apply to those not of their specialty.

Within this area of ethical draftsmanship it must always be borne in mind that nationally accepted standards will probably be rather general in their pronouncements, while local standards may justly be somewhat more specific. This would be so because the standard of professional conduct in the profession in a large municipal medical center might vary quite a bit from the standards in a small rural community.

The desirability of such a definition of standards would seem self-evident. Not only would it serve to provide a proper notification to an offender so as to insure due process, but it would benefit the entire profession in several other distinct ways.

To preserve for the profession that high standard of perfection that it deserves and needs, will require that all physicians be held to the highest possible standards. Enough venial sins can damage you every bit as much as the mortal sins with which we are usually concerned.

It is not valid to assume that all medical practitioners are properly aware of the full scope of professional ethics. Many of our American medical schools do not even teach courses in the subject, it being presumed that the young doctor will absorb the standards more or less by osmosis as he goes through his training.

What is more, we are becoming more and more reliant upon foreign-born and foreign-trained physicians of whom we often know very little. These doctors meet a crying need and help to fill the gap made by our failure to train enough physicians at home. But they also point up a need for well-defined and well-published canons of ethics and practice. To these men, if to no one else, we owe a duty to spell out our standards.

It should also be noted that in this day and age the doctor's potential for financial reward has gone to great heights. The field of medicine can be expected to attract a certain number of men who have more interest in the financial benefits to be derived than in the ancient concept of dedicated service to humanity. Such men may always have been with us but perhaps their number is subject to increase.

A dedicated effort to formulate, restate, keep current, and enforce such ethical and professional standards would have the salutary effect of making the professional rank and file more and more alert to the erosions which might otherwise creep up and undermine the practice of medicine as we now know it. You may find problems which you never dreamed existed. If you are alert you can protect yourselves. If you are not, you may one day find a scandal has come to life which will prompt a state or federal legislature to seize the initiative from the defaulting hands of those who should have done their own policing. This should be avoided at all costs.

No doctor should be abused and damaged by unfounded rumors or malicious bias, therefore the recommendations for full legal safeguards and secrecy of proceedings; but also offenders should not go unpunished and thus cast shame on the profession and cause injury to the public—therefore my suggestion for a definition of principles.

It takes courage to bring charges against a fellow practitioner. He may be a personal friend. But if he is forewarned and knows that he is expected to live up to the fine standards and yet fails to do so, it would be foolhardy to let him run his course. Your profession can be great only if you keep it so through jealous and diligent protection of its standards.

Relation of Grievance Committees and State Boards of Medical Examiners

GEORGE A. WOODHOUSE, MD
Chairman, Judicial Council American Medical Association

There must be good relations between *all* medical society committees concerned with the good conduct of their members and the state boards.

Too often both the public and the medical profession forget the purpose of a grievance committee. When the true purpose of a grievance committee is forgotten, the reasons for its cooperation with other groups are forgotten.

The Guides for Medical Society Grievance Committees, published by the American Medical Association, state that the purpose of grievance committees is to prevent or to resolve misunderstandings and to clarify and adjust differences between the physician and patient. The Guides continue to suggest that when grievance committees are properly organized and operated they can accomplish these objectives with increasingly improved public relations.

Grievance committees receive all kinds of complaints and investigate most of them. If possible, they mediate or arbitrate the complaint. If not, they refer the matter to an appropriate body for further action.

Presented February 6, 1962, Annual Meeting of the Federation of State Medical Boards, Chicago, Illinois.

It is clearly stated in the Guides that discipline is not a proper function of a grievance committee under any circumstance. Medical society discipline is the function of the appropriate judicial body of the society.

The purpose of an ethics committee or a board of censors is to hear and resolve complaints of unprofessional or unethical conduct by its members. The purpose of this type of committee is to police the society's membership. A board of censors handles matters of discipline within the society whereas a grievance committee handles complaints between a member of the lay public and a member of the society.

We have every reason to believe that grievance committees and boards of censors, by and large, accomplish their purpose. In the vast majority of instances their duties are discharged with care. Occasionally, however, a grievance committee or a board of censors is presented with a more serious or a novel complaint. Does it act as promptly and effectively in this instance as it does in the more or less routine case?

There are unexplored areas which need our attention if we are to develop good working

relations between medical society committees and boards of medical examiners.

A key question is jurisdiction. This is important to all three groups. A complaint about the size of a fee is properly within the jurisdiction of the grievance committee. Is it within the jurisdiction of that committee to consider the complaint of a patient that her doctor was intoxicated?

No one would question the jurisdiction of a board of censors to take action on a complaint that a society member violated the Principles of Medical Ethics because he solicited patients. Should a medical society take action against a member who has been fined on his plea of guilty to a charge of federal income tax evasion?

Besides these questions, there are others we must answer. Should a local, that is a county medical society, deal directly with the state board of medical examiners? Should the state board deal directly with the county society's committees? What formal liaison should there be between state and county medical society committees and state boards of medical examiners?

State medical societies undoubtedly should give serious consideration to this three-way relationship. The information which is available at the local level, plus the manpower which is available for investigation, should be utilized to the fullest extent. But this information and this manpower should be utilized efficiently.

Perhaps it would be well to develop a direct and continuing relation at state level between medical society and board of medical examiners. Exploratory meetings should be held and one of the first items of discussion should be the relation between county medical society committees and the state medical society and the board of medical examiners. Members of the state grievance committee, if there is one, and members of its council or its judicial council should be present. The purpose of this liaison should be to develop a working relation at state level.

Experiences should be exchanged, files opened and suggestions freely made. The relation should be such that neither society nor board err or suffer inconvenience in the same manner that the other had. Mistakes should not be repeated because of lack of communication or a lack of warning.

Perhaps now is the time to start thinking about the development and maintenance of central files at state level. There may be legislative, legal or just practical problems connected with the establishment of such files. Now is the time to find out what these problems are. If they are serious, now is the time to correct them. If relations between grievance and ethics committees and the board of medical examiners are to be helpful, some sort of assembled information would seem desirable if not essential.

Of course, it goes without saying that both the state board and the medical society committees should maintain a relationship which would enable one to refer matters to the other to handle. Relations should develop to the point where each would help the other gather facts to prove or disprove charges under investigation. Some day state boards will have full-time, well-trained investigators. Perhaps when that day comes relations will have developed to the point where the investigator may be loaned or the results of his investigation made available to the grievance committee or board of censors of the medical society.

By the same token, members of grievance committees and boards of censors should be willing to lend themselves, their time and their talent to help the boards conduct investigations. There are many cases where a doctor at community level can gather some small bit of information for the board, thus eliminating a trip for the board or its staff. The savings to the board would far outweigh the expense to the doctor.

We have heard of some unpleasant situations because attempts to cooperate were not fruitful or because there was no attempt to cooperate. A medical society should not concern itself with trying to punish a violation of the medical practice act and a board should not concern itself with trying to discipline for a violation of the Principles of Medical Ethics.

There are other medical society committees which should be included in this discussion of good relations—review or utilization committees. More and more, these committees will develop information that requires disciplinary action. It may well be that the board of medical examiners should be acquainted with this information.

Each committee and every board should make a report annually. This report should be considered

tangible evidence of the group's stewardship to the public and the profession.

The committee or board that does not believe it is obligated to the public and the profession is deluding itself. In those matters which effect or influence the physician-patient relationship, the patient has a right to know medicine is policing itself for patient's welfare. The sooner we realize the full extent of this obligation, the easier our task will be. We will appreciate that we are not sitting in judgment on our fellow physician but, instead, are resolving misunderstandings or preventing abuses which cause medicine to suffer.

The Report of the Medical Disciplinary Committee carried two exhibits which reported the disciplinary action taken in 1960 by state medical societies and state boards of medical examiners. These exhibits reported disciplinary actions *only* and this was the first time an effort was made to assemble national figures on medical discipline.

Despite these extenuating circumstances, it is unpleasant to note that 13 state boards and 31 state medical societies are listed as not having taken any disciplinary procedure at all during the year 1960. There may be, and undoubtedly are, reasonable explanations for these omissions. We need to know and we need to make public the number of disciplinary actions taken during the preceding year. Unless an adequate system of record keeping is maintained, unless reports are made by county societies to state societies, unless reports are made by state societies to their membership, and unless reports are made by state boards, full value will not be obtained from our efforts. It should go without saying that half the effect of disciplinary action is lost if the action is kept "top secret."

The Medical Disciplinary Committee suggests, "Each state board of medical examiners make an annual report of its disciplinary activities to the governor of its state, sending copies of its report to the state medical association, the American Medical Association, and to the Federation of State Boards."

These reports need not, and should not, contain names of the doctors called before the committee or board. The item of first importance is that discipline was taken or that a grievance was resolved. Following in order would be the number of actions taken, the nature of the complaint or offense, and finally, the disposition of the matter, that is, what punishment was imposed or what solution was reached.

Many county societies do report grievance committee activities in this manner. Their reports are educational to their membership. Their reports are valuable to all medicine. And their reports have not embarrassed anyone, nor have these reports precipitated litigation. On the contrary, these reports are concrete evidence that medicine is interested in its relations with the public.

As we discuss relations between medical society committees and state boards of medical examiners, we are aware that a discussion of the subject at a meeting like this does not exhaust it. We need to think more and talk more about relations between these two groups.

We can and should work together. Grievances, violation of ethical principles, violations of medical practice acts do occur. Our responsibility is to see that they do not occur. We must educate, we must discipline. As doctors, whether we represent a grievance committee, a board of censors, or a board of medical examiners, our ultimate goal is the same.

As we serve medicine and the public we must not permit our interprofessional relations to deteriorate. To the contrary, individually and collectively we must strive to make these relations as near perfect as humanly possible.



Your MEDICAL FACULTY at Work

JOHN SARGEANT EXECUTIVE SECRETARY

The Council at its January 25, 1968, session took the following actions:

1. Ratified Physicians' Defense for various members who requested it.
2. Denied Physicians' Defense for (a) a member who had failed to pay his dues by January 31 of the year in which the alleged offense occurred; and (b) a member whose application for membership was dated after the alleged offense occurred.
3. Heard that a case was considered closed because it was dismissed for want of prosecution and that judgment was entered in favor of the defendant for costs.
4. Approved recommending Emeritus membership to the House of Delegates for several members whose component society had requested it.
5. Remitted 1968 dues for a member on account of illness and at the request of his component society.
6. Voted to support the concept of legislation that would remove all reference to abortion from Maryland's criminal code; and leave this as a medical decision; and adopted "Guidelines for Hospital Medical Staffs for the Performance of Therapeutic Abortions."
7. Appropriated up to $200 from the educational fund for the purpose of conducting the 1968 Seminar on the Medical Aspects of Sports to be held in conjunction with the Catonsville Community College.
8. Approved a proposed Physical Examination Form and Guidelines for Medical Evaluation of Candidates for School Sports.
9. Adopted the report of the Ad Hoc Committee on PKU Legislation.
10. Deferred action on a recommendation dealing with Mumps Virus Vaccine.
11. Approved a recommendation that would establish a voluntary Central Cancer Registry under the auspices of the Faculty, in cooperation with the American Cancer Society and the Regional Medical Program.
12. Referred for further study a recommendation for Workshops on Cancer Detection.
13. Declined to take action on a proposal to oppose the transfer of Tuberculosis patients from City Hospital to Mount Wilson Hospital because this was in Baltimore City Medical Society jurisdiction.
14. Adopted an official statement dealing with Air Pollution.
15. Approved co-sponsorship of a Statewide Seminar on Respiratory Diseases, along with the Maryland Academy of General Practice, the Maryland Tuberculosis Association, the United States Public Health Service, the Maryland Thoracic Society and the State Department of Health.
16. Elected Arthur T. Keefe, MD, Chestertown, to succeed Eldridge H. Wolff, MD, deceased, as a councilor from the Eastern District.
17. Selected March 31, April 1 and 2 as the dates for the 1971 annual meeting in Baltimore.
18. Stated it would be receptive to a suggestion to hold the 1969 annual meeting at the new auditorium-seminar complex at The Johns Hopkins University School of Medicine; but asked for further details.

19. Recommended various Blue Shield Board and Committee appointments to the Nominating Committee of Blue Shield.
20. Approved the 1968 budget as recommended by the Treasurer and Executive Committee.
21. Authorized expenditure of up to $2,000 for employment of actuarial assistance if needed to develop statistical data or figures for discussion with the State Government or Legislators.
22. Authorized an official statement of the Council in connection with the current studies of fees paid to a certain group of physicians in the operation of the Title 19 program; and requested an audience with the Governor to discuss this. (see statement in full below)
23. Referred a proposal in connection with Health Manpower Recruitment to the Public Relations Committee for consideration and report.
24. Authorized a pilot program of information and education through distribution of pamphlets to selected patients, and approved expenditure of up to $500 from the educational fund for this purpose.
25. Requested the MEDIC Subcommittee to investigate other means of financing the MEDIC network than as is presently done through the Educational Fund at a cost of some $17,500 per year.
26. Rejected a proposal that the Faculty withdraw all sponsorship of overseas travel in accordance with the President's request.
27. Reaffirmed a previous decision that Blue Shield be used for the purpose of making payments under Maryland's Medical Assistance program.
28. Authorized the Professional Medical Services Committee to request formal approval of payment under Workmen's Compensation of the Physician's Usual Customary and Reasonable Fee.
29. Distributed a memorandum dealing with the AMA's reasons for non-participation by AMA on Educational Television in a national debate on Health Care.

STATEMENT OF COUNCIL ADOPTED THURSDAY, JANUARY 25, 1968 IN CONNECTION WITH TITLE 19 PROGRAM OPERATION IN MARYLAND

The Council of the Medical and Chirurgical Faculty of Maryland takes the position that it will continue to urge its physicians, for the time being, to support the Title 19 program. The matter will be reconsidered not later than the Council's March 28th meeting.

In the meantime, it is requesting an audience with the Governor and State legislative leaders to exchange information and to insist on a solution to the overall problems of the Title 19 program.

For the past 22 years, the medical profession has subsidized the medical care program to the extent of at least 10 million dollars per year. It is difficult to envision successful execution of a more comprehensive program for additional persons with a 2½ million dollar reduction in physicians' services from last year's budget, which was, in itself, grossly inadequate, especially since all other services in the proposed medical care program budget remain at the same level as last year, or have been increased. The physicians of Maryland would like to lend support in making the program more effective and more efficient by participation in improved program planning.

The Council expressed grave concern over whether or not physicians who have been singled out as receiving "exorbitant fees" under the Medicaid program will wish to continue caring for such patients. If they elect not to do so, it is a question of where these patients will receive their care.

Those physicians practicing in areas where the preponderance of patients are on public assistance deserve the undying gratitude of the medical profession, the public, the Governor and the Legislature.

Hospital outpatient departments are already overcrowded and overburdened with work. In addition, it would cost the state more than double the amount paid to physicians to take care of the same patient in a hospital outpatient department.

As revealed in discussions connected with this program, patients prefer receiving their care at the private physician's office, where more personalized service can be given.

The Heart Page

CHRIS PAPADOPOULOS, MD, EDITOR

A service of the Heart Association of Maryland

THE RENIN-ANGIOTENSIN SYSTEM AND HYPERTENSION

GLENN D. LUBASH, MD
Associate Professor of Medicine;
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University of Maryland School of Medicine
Established Investigator of the American Heart Association

In this year 1968, synthetic angiotensin is available in ampules, and human angiotensin which eluded isolation for just over a decade has now been characterized. Aldosterone assays are commonplace, plasma renin assays have become clinical tests in addition to research tools, and radioimmunoassays of angiotensin seem only a few years away from the same possiblity. Over the last 30 years a series of brilliant investigations have unraveled renin-angiotensin-aldosterone biochemical and physiological interrelationships. Expectations of concomitant understanding of the pathogenesis of hypertension have been only partially realized, however. At this time, it seems appropriate to review advances in this exciting area, to reassess the role of renin and angiotensin in blood pressure control, and to outline territory still in need of imaginative exploration.

Renin-Angiotensin System

Renin is manufactured, stored, and secreted by renal cortical juxtaglomerular (JG) cells located in the wall of afferent arterioles of the glomerulus. The specialized tubular macula densa cells of the ascending limb of Henle's loop are in intimate contact on one side with the renin-containing JG cells and on the other with tubular fluid leaving the loop of Henle. Thus, anatomical arrangements are such that changes in renal arterial perfusion pressure and in urinary sodium content can be appreciated by receptors located in these strategic sites. In response to decreased perfusion pressure or increased tubular sodium, the system is set in motion and renin secretion is enhanced. Renin is an enzyme with no known direct pressor function. It ruptures a leucine-leucine bond in its α-2 globulin substrate, and the biologically inactive decapeptide, angiotensin I, is released. A plasma substance called converting enzyme cleaves two additional amino acids to produce the octapeptide, angiotensin II, which has several important and potent biological activities.

Angiotensin II is by weight the most powerful pressor substance known. It also affects renal handling of salt and water in such a way that it is an antidiuretic in normals and a diuretic in severe hypertensive patients. This difference has never been adequately explained. Angiotensin II stimulates two adrenal gland functions as well: Catecholamine secretion is increased in acute experiments, and aldosterone secretion from the cortical zona glomerulosa cells is also increased. Under the influence of aldosterone, increased renal tubular potassium-for-sodium exchange results in sodium (and water) conservation. In the negative feed-back part of the system, these last changes signal the JG apparatus to decrease renin secretion. It should be apparent that salt and

water depletion will increase renin-angiotensin system activity and that repletion will decrease it. Thus, this biochemical and physiological chain-of-events exquisitely maintains salt and water homeostasis.

Clinical Variations

Clinical changes in plasma renin activity (PRA) are easily understood. Because of the slight decrease in renal plasma flow in the upright posture, PRA increases slightly compared to that in the recumbent position. Thus, there is some diurnal variation. PRA is also increased in the luteal phase of the menstrual cycle and during the third trimester of normal pregnancy, but these changes are less easily explained. PRA and serum sodium concentration are inversely correlated, and anticipated increases in PRA do occur in Addison's Disease and "salt losing" renal disease. Since other factors such as plasma volume also affect PRA, the situation in congestive heart failure is more complex. Expanded plasma volume will tend to decrease PRA and diuretics to increase it. Cirrhosis with ascites, nephrotic syndrome, and hemorrhage are frequently associated with serum hyponatremia or decreased plasma volume, and PRA may be elevated. Aldosterone excretion rates are also increased, presumably due to the influence of renin and angiotensin. The aldosterone excess is properly characterized here as "secondary." Blood pressure is most frequently normal (or even low) in these conditions.

In hypertension, the same inverse correlation with serum sodium holds, and this is the only constant relationship which is apparent. Etiology of hypertension, duration, severity, complications, and treatment do not seem to affect PRA. The only exceptions are (a) malignant or accelerated hypertension where increased PRA and secondary aldosteronism have been described and (b) antihypertensive therapy with diuretics where sodium balance is changed. In renovascular hypertension, PRA has been found to be normal and high, but the overlap of these results with those found in other hypertensive or normotensive states precludes diagnostic usefulness. More precise correlation of diagnosis with bilateral renal venous PRA and inferior vena cava PRA is presently being sought.

PRA determinations are extremely helpful in distinguishing between primary and secondary aldosteronism. In the primary situation, aldosterone secretion from the diseased adrenal gland (adenoma or hyperplasia) is autonomous. The hormonal action to produce salt retention causes suppression of renin secretion. Low or absent PRA results, and the suppression cannot be overcome by usual stimuli such as salt restriction, upright posture, and diuretic therapy. When PRA is normal, high, or responsive to positive stimuli and associated with increased aldosterone excretion, secondary aldosteronism is said to be present. In practice, PRA assays under these conditions supplement other means of testing for primary aldosteronism.

Blood Pressure Regulation

Though there is no apparent parallelism between renin and arterial pressure, some role for renin and angiotensin in blood pressure regulation may still be possible. Such a role must take into account another determinant of blood pressure response, sensitivity of the arterial wall smooth muscle target tissue.

In such conditions as cirrhosis, Addison's Disease, and pregnancy where serum sodium is low and PRA is high, pressor sensitivity to infused synthetic angiotensin II amide is decreased. Increased sensitivity has been demonstrated in reverse situations where sodium is high and PRA is low, eg, primary aldosteronism, DOCA excess, and salt-replete normals. Though renin (angiotensin) and blood pressure responsiveness vary in opposite directions, the amounts of circulating renin and angiotensin may be important determinants of the changed responsiveness to infused pressor substance. Stated another way, it seems quite possible that variable amounts of renin and angiotensin are required to raise blood pressure and that changes in plasma concentrations of these substances are important contributors to the response. That such variation in sensitivity to renin and angiotensin occurs within the clinical range of renin measurements has been documented in animals and supported by some studies in humans. The most likely factor responsible for these changes in vascular smooth muscle sensitivity seems to be redistribution of arterial wall electrolytes. In any case, the proposition that the renin-angiotensin system helps to regulate

blood pressure both by the amount of circulating renin and angiotensin and by related responsiveness to these same substances seems worthy of critical evaluation. How dietary sodium affects the pressor response remains to be explained.

Future Investigations

There are many unknowns and uncertainties in the overall renin-angiotensin scheme. The precise stimulus responsible for renin secretion must be further pinpointed within the JG apparatus or macula densa. Renin must be purified, characterized, and restudied physiologically. Assays of PRA are presently quite crude. Those of renin concentration are more accurate but also more cumbersome. Better methods for renin and angiotensin assay must be devised. Characterization of converting enzyme has not yet been possible. Various enzymes (angiotensinases) which degrade angiotensin *in vitro* may vary in some disease states and may have some role in blood pressure control. Clarification of the role of these proteins will probably not be possible until isolation of specific enzymes has been accomplished. The relationship of the renin-angiotensin system to catecholamine metabolism is an exciting new field for investigation. Variations in renin substrate could have a role in blood pressure regulation. Finally, the pathogenesis of essential hypertension has so far eluded definition on a renin-angiotensin system basis or, in fact, on any basis. These unanswered questions and others should stimulate continued and vigorous investigations.

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State of Maryland
Department of Health
WILLIAM J. PEEPLES, MD, MPH, COMMISSIONER

Rubella Syndrome Subject of MEDIC Program

A comprehensive seminar on the identification and referral of rubella-damaged children will be presented over the MEDIC network Thursday, February 29, from 1 to 4 P.M. The possibility that as many as 6000 children may be victims of congenital rubella as a result of the 1964 epidemic has grave implications for educators as well as medical care personnel. The importance of identifying these children before they reach school age is the basis for the MEDIC presentation, a joint effort of the School Health Section of the Division of Maternal and Child Health, and the Exceptional Children's Committee of the Maryland State School Health Council.

HIGHLIGHTS

Additions to Laboratory Capabilities

The Biochemistry Division of the Bureau of Laboratories for more than a year has had the capability of automated blood sugar determinations on micro-quantities of blood for detection of diabetes in screening programs. Recently, the capabilities of automated procedures have been extended to determinations of blood cholesterol for guidance in assessing arteriosclerosis, blood uric acid for detection of gout, and blood urea nitrogen for evaluating kidney disease. (These multiphasic determinations have not yet been developed for micro-methods.) The addition of these increased capabilities in public health biochemistry will aid materially in programs for the early detection of previously unrecognized chronic illnesses in which early medical management can greatly improve community health.

Governor Rescinds Medical Assistance Cutback

On December 29, 1967, Governor Agnew directed that Medical Assistance to persons aged 21 through 64 be limited to federally-assisted categories. The action affected some 10% of the 270,000 eligible recipients. In response to petitions from various concerned sources, and after further consultation with his fiscal advisers, the Governor wrote to the Commissioner on January 5, 1968:

"I shall recommend to the 1968 General Assembly a deficiency appropriation of $5,000,000 for this program. Please make all administrative arrangements to continue to pay medical expenses of these 27,000 persons to the extent made possible by this additional appropriation."

The Governor warned, however, the program would face curtailment July 1, as continuation at the present level would require an $18,000,000 increase for the next fiscal year. He expressed the hope that the Federal plan would be revised to provide incentives for more efficient hospital operations, and requested the Department to appeal Federal regulations which presently prohibit the State from effecting economic restrictions in the program's provisions.

A-2 Influenza Confirmed

The Bureau of Laboratories' Division of Virology early in January isolated A-2 virus from specimens collected during a year-end outbreak of illness among high school students in Allegany County. This confirmed earlier serological studies which had shown "a significant rise in antibody titres to the A-2 type influenza." Isolations of para-influenza 3 virus from several Allegany County specimens and one from St. Mary's County indicate more than one virus may have been involved in the outbreaks of illness which have occurred in other counties of Maryland.

University of Maryland Food Service Facilities Found Lacking

A father's complaint that his daughter had been made ill by contaminated food served in a University of Maryland dining hall prompted a state senator to request inspection of the facilities by the Division of Food and Milk.

On receiving the Division's report of the preliminary inspection of one dining hall, the senator released the information to the press, which took intense interest in the ensuing inspection of this and other University food service areas. Less well publicized has been the response of University officials, who have taken steps to improve the areas where deficiencies were noted, and have promised cooperation with the Health Department to effect further needed improvements. Division sanitarians have found no evidence that food is inferior in quality at the time of delivery to the University.

Screening Program Locates New Diabetics

Diabetes screening during the past year in six Maryland locations tested 6,423 persons, mostly in the high risk group, with 142 new and 52 borderline cases identified and given intensive follow-up to insure that physician referrals were accomplished. These findings were reported by the Adult Services Division, Bureau of Chronic Diseases. Four of the screenings were in the Baltimore area (Fifth Regiment Armory, Jewish Community Center, Harlem Health Fair, Social Security Administration), others in Salisbury and Westminster. Co-operating with the State Health Department in the project were the Maryland Diabetes Association, Baltimore City and Wicomico Health Departments, the Social Security Administration's Medical Department, Maryland Pharmaceutical Association and the Women's Auxiliary of the Medical and Chirurgical Faculty.

During the recent Maryland Health Fair, an additional 3,551 persons were tested for diabetes with 387 screening positive. These individuals are being retested and referred to their local physicians for final diagnosis and treatment if necessary. Laboratory work for the screenings and retesting is being done by the Bureau of Laboratories. It is anticipated a considerable percentage will be identified as new diabetics.

Department Assists CBS Smoking Program

In cooperation with the Heart Association of Maryland, the Maryland Tuberculosis Association, the Maryland Division of the American Cancer Society, and the Maryland State Department of Education, the Health Department assisted in the distribution of more than 1 million National Smoking Test forms which were used in conjunction with an audience participation telecast January 16 over the CBS network. Most of the test forms were distributed through the public school system, to all pupils. Forms were also distributed through non-public schools, colleges, industries and retail druggists.

One part of the test, "Insight Development Questionnaire," was designed to give smokers a better understanding of what motivates them to smoke, and hopefully to help them quit the habit.

Clinical Laboratories in Maryland High in Performance

A recent proficiency testing program, conducted by the Bureau of Laboratories, revealed a relatively high level of performance in biochemical determinations performed by private clinical laboratories. Previously assayed blood serum specimens were distributed periodically to 98 hospital and clinical laboratories throughout the State, each laboratory performing three tests on each of seven constituents, or a total of 21.

In the determinations of serum chloride, sodium, calcium and total protein, 85% of the laboratories attained a score of at least 95% accuracy. In the determinations of glucose and potassium, 84% scored 90% or better. In urea determinations, 78% scored over 80% accuracy.

For the relatively few laboratories which showed poor proficiency in the tests, the Bureau will give consultation and training to improve performance. The proficiency testing program, offered on a voluntary basis by the Bureau for close to 20 years, is now mandatory under the 1966 Federal law and regulations governing clinical laboratories.

Newly appointed Chief of the Division of Certification and Field Services is Calvin B. Galloway, MD, RAdm, MC, USN (Ret.). During his naval career, Dr. Galloway commanded laboratory and research activities both in the United States and overseas.



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study I[1]

Results of a 1967 in vitro—in vivo correlation study involving 116 patients with Gram-positive coccal infections in five institutions. All patients were given TAO prior to determining the susceptibility of the offending organism.

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study II[2]

Effect of oral therapy with TAO, erythromycin, and cloxacillin on the survival time of Rhesus monkeys after intravenous inoculations of lethal doses of staphylococci, phage type 80/81.
(8 monkeys in each group)

conclusion:

*Under the conditions of this study and the doses employed, it was found that

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was far superior to erythromycin, as was cloxacillin, a bactericidal agent, and of particular interest, "...bacteriostatic triacetyloleandomycin was as effective or perhaps superior to cloxacillin in preventing lethal (staphylococcal, phage type 80/81) infection."

*It should be pointed out that results obtained in an experimental study of this nature may not necessarily be directly extrapolated to the clinical situation as it pertains to man.

AO Rx Information

IDICATIONS: Include streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections here adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents. **ONTRAINDICATIONS AND PRECAUTIONS:** Not recommended for prophylaxis or in the treatment of infectious processes nich may require more than ten days continuous therapy. In view of the possible hepatoxicity of this drug when therapy eyond ten days proves necessary, other less toxic agents should be used. If clinical judgement dictates continuation of erapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the st evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis e suspected, proper diagnostic procedures, including darkfield examinations, should be followed. In other cases in which ncomitant syphilis is suspected, monthly serological tests should be made for at least four months. Contraindicated in e-existing liver disease or dysfunction, and in individuals hypersensitive to the drug. Although reactions of an allergic ture are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions. When used in reptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or omerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant fection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the edication should be discontinued, and specific antibacterial and supportive therapy instituted.

ferences: 1. Isenberg, H. D.: Clinical Evaluation of Laboratory Guidance to tibiotic Therapy; Health Laboratory Science (July) 1967. 2. Saslaw, S., Carle, H. N.: Studies on Therapy of Staphylococcal Infections in Monkeys. Comparison of Cloxacillin, Triacetyloleandomycin and Erythromycin. Proc. c. Exp. Biol. & Med.: Vol. 125, No. 4 (Aug.-Sept.) 1967.

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CHAS. PFIZER & CO., INC.
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SHERIFF

LOMOTIL®

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Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . . . 2.5 mg.
(Warning: may be habit forming)
atropine sulfate . . . . . 0.025 mg.

Halts Diarrhea Promptly

in children with . . . Gastroenteritis ▪ Spastic bowel
Influenza-like infections ▪ Antibiotic-induced diarrhea

Lomotil helps get children with diarrhea off toast and tea and back to normal diets and normal activity with gratifying dispatch. ▪ Lomotil lowers intestinal motility and permits absorption of excess fluid. This usually controls diarrhea promptly. ▪ Moreover, lowered intestinal motility achieved with Lomotil often relieves the abdominal cramps and discomfort so distressing to children.

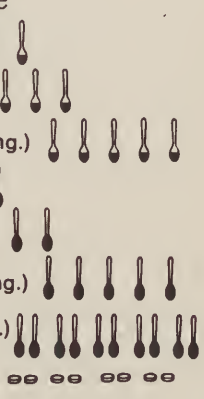
Precautions: Lomotil is a Federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is recommended. Lomotil should be used with caution in patients with impaired liver function or those taking addicting drugs or barbiturates.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of the extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

Children: Total Daily Dosage

3-6 mo. . .½ tsp.* t.i.d. (3 mg.)
6-12 mo. .½ tsp. q.i.d. (4 mg.)
1-2 yr. . . .½ tsp. 5 times daily (5 mg.)
2-5 yr. . . .1 tsp. t.i.d. (6 mg.)
5-8 yr. . . .1 tsp. q.i.d. (8 mg.)
8-12 yr. . .1 tsp. 5 times daily (10 mg.)
Adults: . .2 tsp. 5 times daily (20 mg.)
or 2 tablets q.i.d.



*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

SEARLE *Research in the Service of Medicine*

When the agitated businessman goes to work...

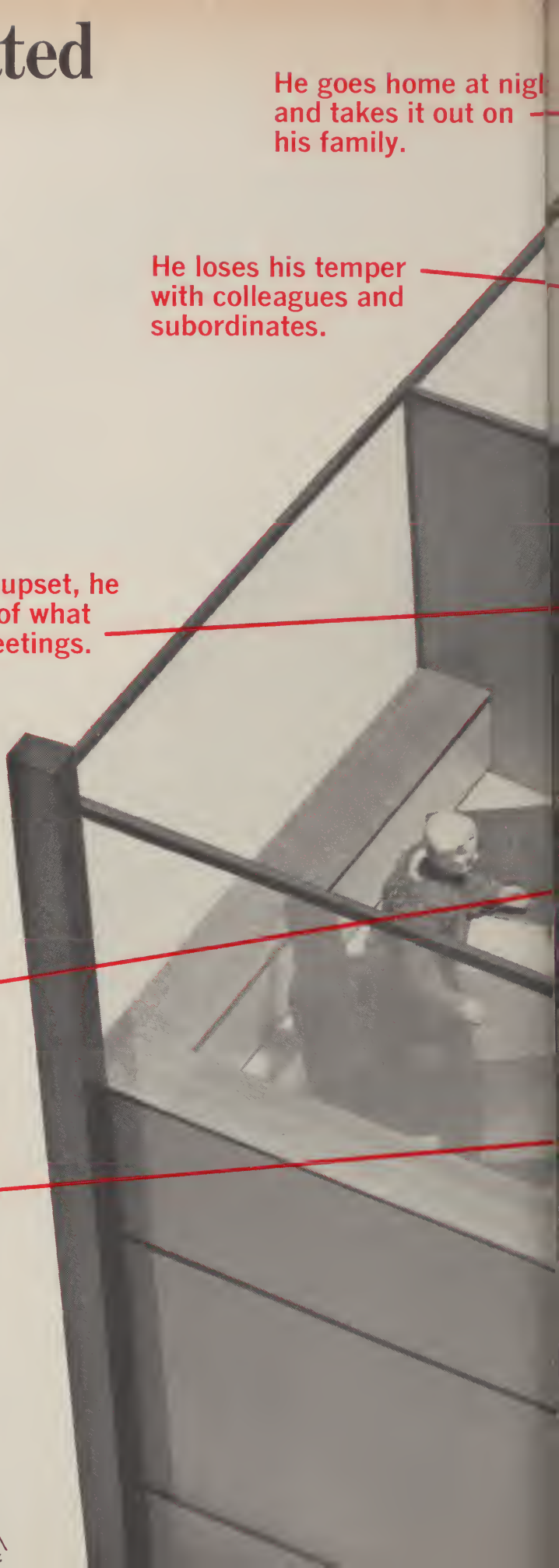
He goes home at nigl
and takes it out on
his family.

He loses his temper
with colleagues and
subordinates.

Emotionally upset, he
misses half of what
is said at meetings.

He is always fearful
about his standing
with the boss.

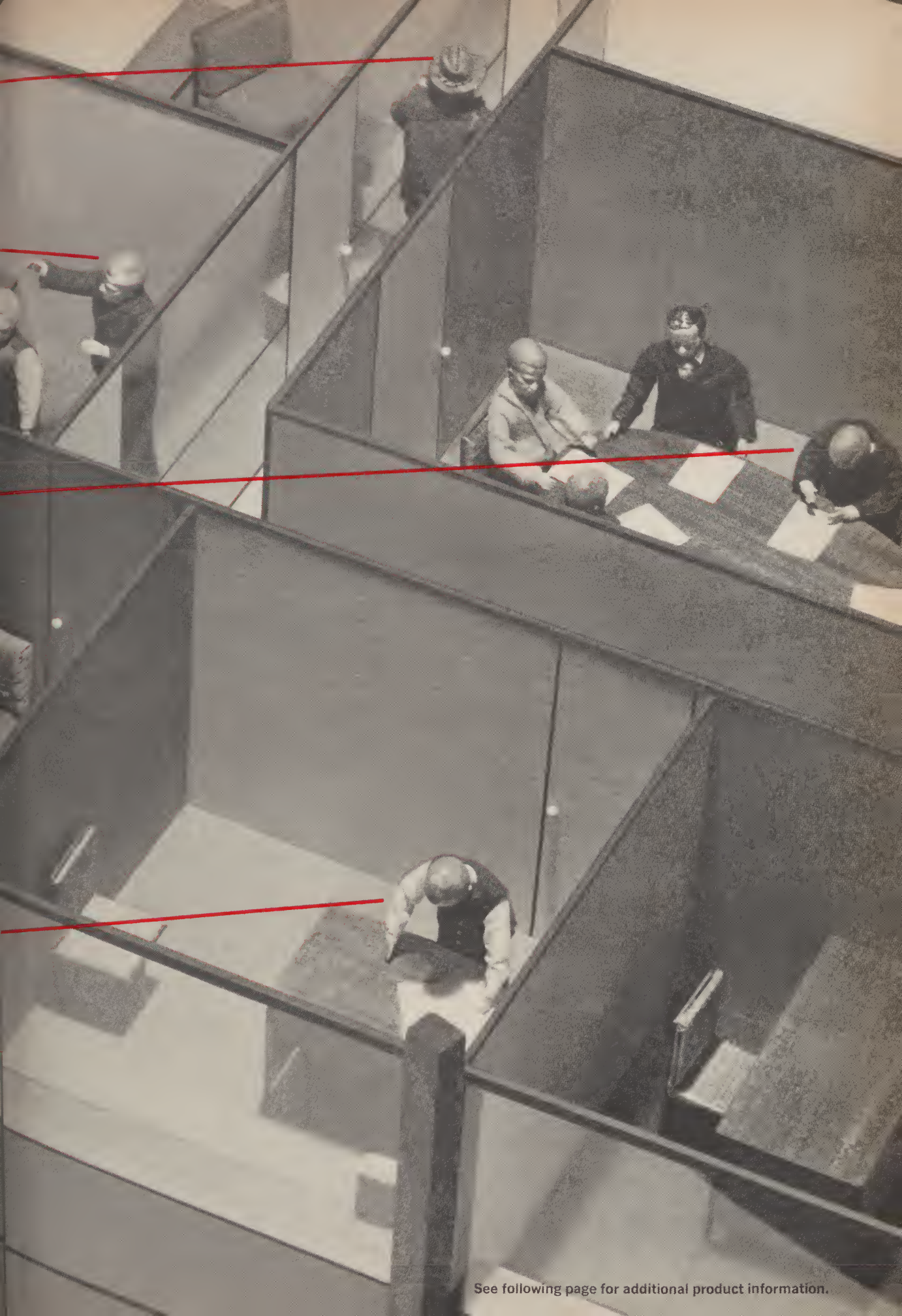
He just can't seem
to settle down
to his work.



for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ



See following page for additional product information.

When the agitated businessman goes to work...

Anxiety that *seriously interferes* with the individual's performance at work, at home, or in the community may be regarded as *moderate* to *severe* in degree.

Mellaril often recommends itself to the treatment of moderate to severe anxiety because it

- helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- often alleviates anxiety-induced somatic complaints
- frequently helps strengthen emotional resources
- helps the patient maintain realistic contact with environment, closer harmony with family

Thus, when you consider the anxiety moderate to severe... consider Mellaril.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

Before prescribing, see package insert for full product information.

for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ

mudrane®

for

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- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 mg.
Aminophylline	130 mg.
Phenobarbital, Caution: May be habit forming...	21 mg.
Ephedrine HCl	16 mg.

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Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

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Woman's Auxiliary

MRS. HARRY L. BERMAN, EDITOR

Medical and Chirurgical Faculty

Since the last board meeting of the Auxiliary to the Medical and Chirurgical Faculty our President-elect, Margery Warres, has met with the Executive Committee of the Faculty to present the National 100% Membership Plan. If it is favorably received, this will enable all of the wives of doctors to become members without having to pay dues. We hope it materializes.

Newsletter Editor, Dottie Sunday, did yeoman service on the excellent issue of Hygeia Filiae which was made possible by the fine response many of the members gave her. She and I pool our information and we thank you most gratefully. Please continue to send us newsworthy items.

Congratulations to our Auxiliary for the $15 awarded us by the Woman's Auxiliary to the Southern Medical Association for the Best State-Wide Observance of Doctor's Day. Credits go to Nellie Robinson and Esther Cohen.

Although Allegany County extended invitations to all County Presidents and Health Careers Chairmen, only Elsie Goldstein and Louise Stone were present to hear Mrs. Herbert Ulrich, a national director of the AMA Woman's Auxiliary, speak excellently on Health Careers. Representatives from the faculties of local high schools and hospitals were in the audience to hear Mrs. Ulrich discuss present problems and the future possible solutions concerning health in the United States.

Alice Radman, AMA-ERF Chairman; Mrs. Genevieve Ritchie from the "Building," and Louise Stone visited the office of the Morris A. Mechanic Theatre, and have reserved 200 center front seats for the night of April 17th for the production of "You Know I Can't Hear You When the Water's Running." Direct from Broadway where it was favorably received by critics and audiences, this light and deliciously funny comedy will star Eddie Bracken. Since April 17th and 18th are the dates of the Annual Meeting of the Medical and Chirurgical Faculty it would be advisable to make plans early for an evening at the theatre. For more detailed information, write to Mrs. H. Melvin Radman, Esplanade Apts, Baltimore; or call Mrs. Ritchie at Med-Chi: Telephone 539-0872.

Elizabeth Linhardt is still working on her members-at-large and has had a response from each doctor's wife. An excellent piece of work.

Elizabeth von Fesus held a morning coffee for all the County International Health Chairmen.

"S.O.S. to all auxiliary members in regard to the Advertising Program of *MD'S WIFE*. The back cover of the January 1968 issue of *MD'S WIFE* will carry an advertisement for the Classics Club, with an attractive offer of three beautifully bound classics (Plato, Marcus Aurelius and Aristotle) for $1. This ad has been accepted under an arrangement whereby the company will pay for the advertising space at the rate of $3 per inquiry. A response of 3,000 inquiries therefore would mean $9,000 for the Auxiliary.

The response will not only affect the advertising revenue for this particular ad, but the AMA Advertising Department would like to have a heavy response to indicate to potential advertisers that *MD'S WIFE* is an effective and well-read advertising medium for their products.

It would be appreciated if YOU WOULD GET IN TOUCH immediately with as many doctors' wives as you can and ask them to clip the coupon, fill it in and mail it quickly to the address given in the ad. It is essential that 25 to 50 coupons come in from each state. At this time there is no more important action you could take to strengthen the Auxiliary's financial situation. Your help and cooperation will be greatly appreciated."

Very sincerely yours,
Margaret Wolfe, Executive Secretary

Baltimore City

A reminder of the Benefit Fashion Show Luncheon to be held Monday, March 11th at the Greenspring Inn Club. It has all the promise of an exciting afternoon. Call Dottie English for information; Telephone: ID 3-6648, or Jane James 433-5858.



when he just can't sleep

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One-Half Sodium Amobarbital and
One-Half Sodium Secobarbital
supplied in ¾, 1½, and 3-grain Pulvules



Tuinal helps wakeful patients fall asleep fast, stay asleep all night.

Indications: Tuinal is indicated for prompt and moderately long-acting hypnosis. It is not suitable for continuous daytime sedation.

Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. Symptoms—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. Treatment—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



Dosage: 50-200 mg. (¾-3 grains) at bedtime.

[031767]

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Baltimore City Health Department

ROBERT E. FARBER, MD, MPH, COMMISSIONER

Public Health In Baltimore In 1967

The following is a summary of some of the noteworthy public health events that took place in Baltimore during 1967. Much of the positive nature of this report is due to the valuable contributions of the physicians in the city, the state and city medical societies, our medical institutions, and the many official and non-official groups that are concerned with the health of our residents.

The solution of the negative aspects requires intensive efforts through new and continuing programs by all concerned. The following also presents some new Health Department approaches and observations on the solution of the city's significant health problems.

Positive Elements of the City's Health

1. The infant mortality rate estimated at 26.8 infant deaths per 1,000 liveborn is at the lowest level ever recorded. This is due to marked reduction in the infant loss among Negro liveborn and more particularly among infants born to mothers in deprived socio-economic circumstances.

2. The loss of life among mothers, due to childbirth, declined to the lowest level previously experienced in this City. Seven such deaths were recorded compared with 13 in 1966.

3. A further decline in fertility rates gave evidence of the widespread and increasing use of family planning practice in all segments of the community.

4. The reported cases of measles plunged to near eradication levels due to the continuous efforts of physicians in private practice and Health Department programs including the state-wide mass campaign conducted by the state and city medical societies and the health departments in cooperation with many community groups.

5. A mild 'flu' year accounted for a 20% drop in pneumonia deaths and also contributed to a 5% decline in deaths due to cardiovascular conditions.

The Problem Areas

1. The incidence of new cases of tuberculosis and the number of deaths due to tuberculosis changed insignificantly from the past three-years' experience and continues at relatively high levels.

2. The burgeoning number of cases of gonorrhea (6,685 in 1967) is indicative of widespread promiscuous sexual relationships.

3. A continuing high rate of early teen-age pregnancy as evidenced by approximately 1,000 births to girls 16 years of age and younger. This represents a problem of catastrophic social and economic significance.

4. A further rise in lives lost due to murder, reaching a new record level of 192, is also evidence of social pathology of unparalleled magnitude within the community.

5. A high rate of retarded verbal development in young school children.

6. Low levels of sanitation including rodent infestation in substantial areas of the city.

New Efforts

Among new efforts launched in 1967 to improve the health of the City's residents, several of the more important are:

☐ Establishment, as a permanent program, of a Bureau of Special Home Services to help the aged and chronically ill; ☐ The opening of two additional Comprehensive Pediatric Centers, one at the University of Maryland Hospital and the other at the Baltimore City Hospitals; ☐ The approval of a grant by the Office of Economic Opportunity to the Provident Hospital for the purpose of establishing a Neighborhood Health Center in West Baltimore; ☐ A rat eradication

program which was established in August with special funds made available by the Governor.

The problem of reducing pregnancy among adolescent girls is subject to partial solution by medical counseling and clinical services. Such services are gradually being expanded. More important, however, is initiative by social and church institutions to improve the physical, social and spiritual environment within which adolescent children grow. With this in mind, leading citizens and citizen groups as well as churches and such organizations as the Girl Scouts, Camp Fire Girls, and the YWCA are called upon to allocate more of their resources to those areas of the City within which adolescent girls mature under severely deprived circumstances.

During 1967, it became increasingly apparent that among those neighborhoods, where poor health conditions generally prevail, there was incisive recognition by individuals in these areas, that their prime need was for economic improvement through job opportunity and for adequate housing so that fundamental family functions could be carried out with some semblance of effectiveness. For this reason there is considerable merit to organization of public services on a neighborhood basis within the central part of the city so that the related efforts of job acquisition, economic assistance, housing improvement, and basic health and social services are integrated within a single complex and under a single local administrator. Hopefully, this approach to provide needed services will upgrade the health outlook and aspirations of our deprived citizens and will ultimately reflect benefits to all our citizens.

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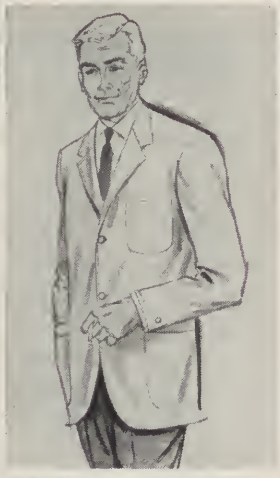
#400—100% Cotton—2x1 Sanforized Poplin **$4.99**

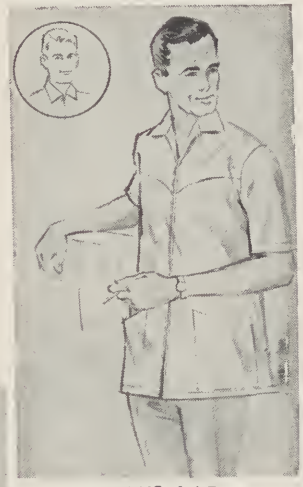
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All men's jackets short sleeves only

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3310—65/35 Dacro-Gab. **$8.99**

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Rehabilitation Notes

DOUGLAS G. CARROLL, MD, EDITOR

CARDIAC REHABILITATION (PART IV) —A Coronary Care Unit

KENNETH B. LEWIS, MD
Assistant Chief Physician and
Chief Cardiovascular Division,
Baltimore City Hospitals
Assistant Professor of Medicine
The Johns Hopkins University
School of Medicine

The recognition of the frequency of cardiac arrhythmias in acute myocardial infarction, and the fact that much of the mortality is due to such electrical disturbances led to the development of special areas where patients with acute myocardial infarction could be admitted and connected to electronic monitors so that cardiac rhythm disturbances could be detected and treated. The concept of coronary care has evolved since 1962 when Hughes W. Day, MD, opened the first Coronary Care Unit in Kansas City, Kansas.

The Coronary Care Unit is similar in one respect to an Intensive Care Unit in that careful observation of patients is carried out by an especially trained group of nurses. Here, however, similarity ends. An intensive care area is usually a large open room, or a series of glass-enclosed rooms where the nursing staff can visualize all the patients from any point. There is often moderate noise due to respirators, suction apparatus, and other equipment.

The careful observation of coronary care should be carried out in a more tranquil setting. This is because after the initial pain has been controlled with drugs, the patient with a recent myocardial infarction may feel quite well. He is usually alert, well oriented, and quite aware of all of his surroundings. He is in need of a quiet restful area, free from noise and stress, in which to recuperate. The necessary noise and activity of an Intensive Care Unit may be quite upsetting to this type of patient and in that sense may offset the positive aspects of being on a cardiac monitor.

Initially, the purpose of a Coronary Care Unit was to immediately detect life-threatening arrhythmias such as ventricular tachycardia and fibrillation, and asystole, so that resuscitative measures could be instituted. As more experience has accumulated in managing patients in this setting, it has become apparent that many fatal arrhythmias are preceded by less serious warning arrhythmias. Thus, frequent premature ventricular contractions may appear as a sign of ventricular irritability before ventricular tachycardia occurs, or varying degrees of incomplete atrioventricular block may develop before complete heart block occurs. It is believed by many investigators that early treatment of these less serious arrhythmias with drugs and pacemakers prevents the development of fatal arrhythmias. It should be emphasized that obtaining statistically significant data to test this approach is difficult because it is almost impossible to get a truly comparable control group. The physician who has watched frequent premature contractions develop into ventricular tachycardia on several occasions is necessarily reluctant to allow this situation to go untreated for the sake of a controlled study.

The important principle in the development of coronary care should be that every patient with

acute myocardial infarction or suspected myocardial infarction should be admitted to this type of unit and monitored. A physician cannot predict which patient is going to develop a potentially serious arrhythmia. The relatively young patient with a myocardial infarction who is presently pain free and completely asymptomatic and resting in bed, may develop, without warning, a potentially fatal arrhythmia, and if not monitored may die because of this potentially treatable episode. It is this type of situation which Coronary Care Units are best suited to prevent.

In July, 1966 an eight-bed Coronary Care Unit was opened in one wing of a medical floor at the Baltimore City Hospitals. In the past 18 months, there have been 580 admissions to this area. The organization of the hospital is such that every patient seen in the Emergency Room with a myocardial infarction, or suspected myocardial infarction is admitted to the unit. If after three days of serial electrocardiograms and enzyme determinations there is no evidence of myocardial infarction, the patient is discharged or transferred to the medical floor for further evaluation. If a myocardial infarction is documented, the patient is kept in the unit for five days or until stable before being transferred to the medical floor for the remainder of his convalescence. It should be emphasized that patients are admitted for observation on the basis of history of prolonged characteristic chest pain with diaphoresis even if the electrocardiogram is normal. It is well known that characteristic electrocardiographic changes of myocardial infarction may not develop until some hours after the pain, and if patients are discharged from the office or Emergency Room on the basis of an electrocardiogram, some will be sent home while evolving a myocardial infarction.

The mortality rate for patients with proven myocardial infarction in the Coronary Care Unit has been 11%. The total overall mortality rate for admission with acute myocardial infarction is currently 17%. This discrepancy is accounted for by a number of patients who die after two to three weeks of hospitalization, while on the general medical floor, and apparently quite stable. The cause for these deaths is currently unknown because of lack of autopsy information. It is presumed that they are related to either re-infarction, arrhythmia without re-infarction, or possibly pulmonary embolization.

The management of various problems in this unit will be discussed below:

1. *General Nursing Care*—We feel that the care of the legs in these patients on bed rest for a period of time is quite important, and the nursing service encourages exercise of the feet against footboards which are present on all beds. Likewise, leg wraps with ace bandages are used constantly while a patient is in the unit. Patients are allowed to feed themselves and it is a rare exception when a patient is fed by the staff.

2. *Heart Failure*—Heart failure manifested by pulmonary edema is obviously treated with the usual measures including mercurial diuretics, bed rest, oxygen and digitalization. However, it has been our practice also to digitalize patients when they develop a clear left ventricular gallop or mild basilar rales and not to wait until more overt signs of failure are present. It has not been our experience that they are more prone to digitalis toxicity and we prefer to treat them at this point rather than take a chance that more severe failure will ensue. It should be emphasized that when these patients have recovered from their myocardial infarction and convalescent period, digitalis should be discontinued for a trial period and many patients will not have to have this drug reinstituted. We do not feel that chlorothiazide diuretics are indicated in the Coronary Care Unit because of their propensity for causing potassium depletion and the increased chance of cardiac arrhythmias.

3. *Myocardial Irritability*—We agree with Bernard Lown, MD, of Boston, that in the presence of ventricular irritability as manifested by premature ventricular contractions in the setting of acute myocardial infarction, suppressive therapy should be instituted. We use intravenous Xylocaine (*lidocaine hydrochloride*) almost exclusively and have been quite pleased with the response to this drug and the lack of side effects associated with it. We use intravenous Xylocaine in single injections of 50 to 100 mg and also as a constant intravenous infusion of approximately 100 mg per hour. If this or other drugs are used as an infusion, they should be given through a volume control set to prevent the inadvertent administration of larger quantities than anticipated. Our criteria for the administration of Xylocaine are greater than 10 unifocal premature ventricular contractions per minute, less than 10 multifocal

premature ventricular contractions per minute, coupled ventricular beats or runs of ventricular tachycardia. If evidence of ventricular irritability persists after 72 hours of an intravenous Xylocaine infusion, we place the patient on oral quinidine sulfate 300 mg every 6 hours.

4. *Heart Block*—Patients with 1st degree heart block are carefully observed but not specifically treated for this abnormality. If 2nd degree heart block develops, they are treated initially with intravenous Atropine and often times with this therapy the improvement in conduction converts this to 1st degree block. If 2nd degree block persists despite Atropine administration or if large quantities of Atropine are required to a point where Atropine toxicity may occur, we prefer to use a temporary transvenous pacemaker to manage these patients. In 3rd degree heart block we would immediately insert a temporary transvenous pacemaker. Once a pacemaker has been inserted it is our practice to leave it in for a minimum of two weeks connected to a Demand pulse generator. With this type of unit, a patient's intrinsic rhythm is maintained as long as it is adequate but if heart block should develop again or the heart rate should slow below a pre-set limit, the Demand unit would take over and pace the heart at whatever rate it was set. Heart block may recur some days removed from the initial myocardial infarction and, therefore, we believe it is safer to leave the pacemaker catheter in for this length of time. A number of deaths have been reported in patients who had recovered from heart block and had the pacemaker catheter removed and who subsequently developed again this conduction abnormality. The persistence of complete heart block after myocardial infarction is exceedingly rare and we have seen only one example of this. This means that one can reassure the patient when putting in a temporary transvenous pacemaker that the odds are very great that it will be only temporary.

Soon after a patient's admission to the coronary unit when his medical condition is stable, discussions should begin with him about what he can expect during his hospitalization. He should understand that as he improves he will no longer need the special facility of the unit and will be transferred to the medical floor. If this approach is used, the ultimate transfer out of the unit is looked upon as a positive step toward recovery rather than a sudden unexpected ousting from the protection of the unit. The convalescent period should also be used as a period of education for the patient as to his activities over the following weeks after discharge and his long term prospects. During this time patients are highly motivated to change habits which increase the risks of coronary disease. For instance, the heavy smoker who has been off of cigarettes for his three-week hospitalization may with discussion and encouragement not resume this habit when discharged. The obese patient or patient with hypercholesterolemia can receive dietary counsel in a setting where he is more likely to be motivated to follow it.

Finally it should be recognized that only 20-30% of patients dying of arteriosclerotic heart disease do so in the hospital and therefore have the opportunity to be cared for in a Coronary Care Unit. Public education to seek medical evaluation for chest pain and the development of special cardiac ambulances equipped with monitors and defibrillators and manned by specially trained personnel may hopefully decrease further the mortality from myocardial infarction.

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Precautions: Antihypertensive therapy with Regroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue Regroton therapy two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Regroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. **Average Dosage:** One tablet daily with breakfast. **Availability:** Pink, single-scored tablets in bottles of 100 and 1000. (B) 46-600-B
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1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



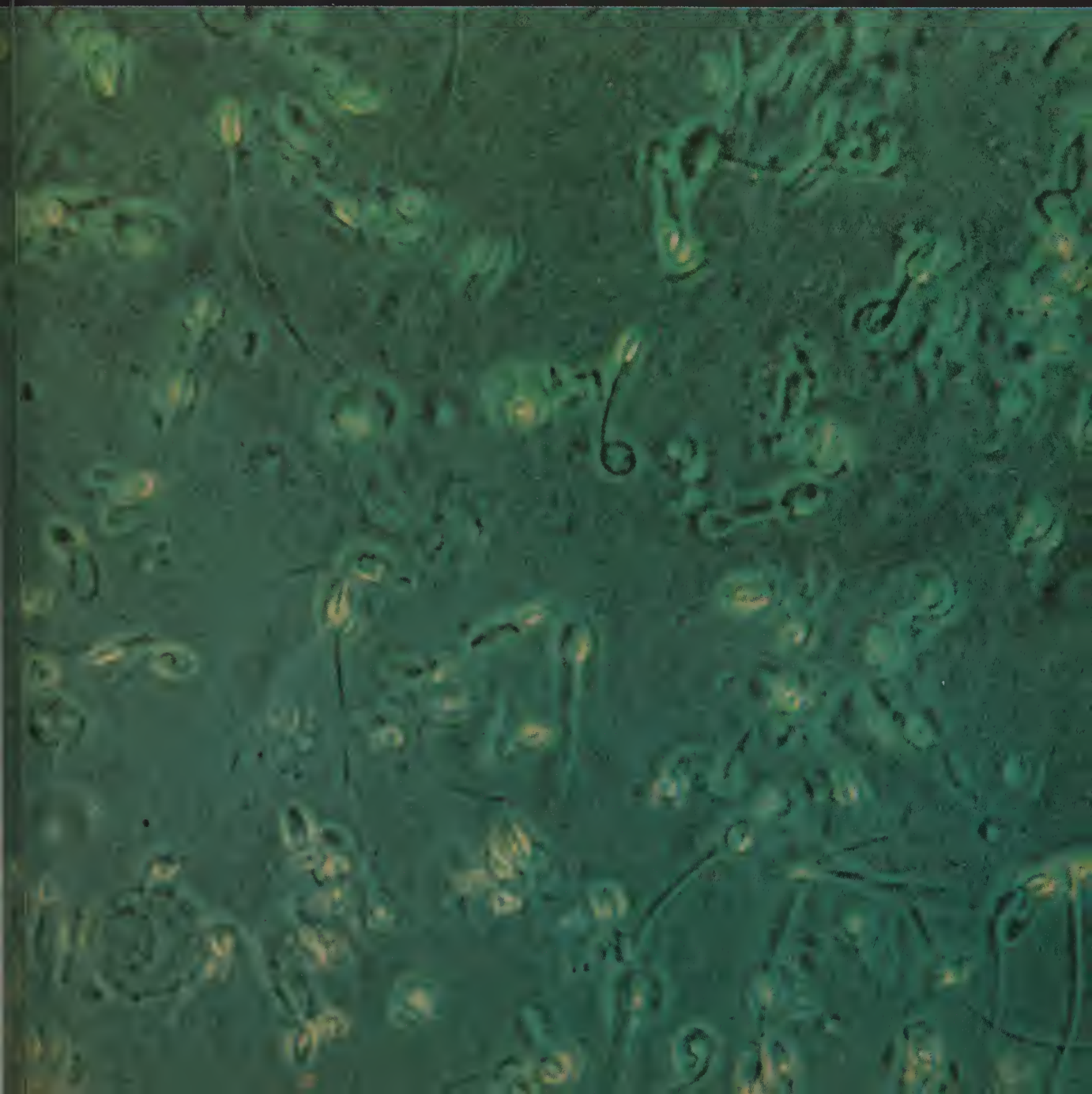
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When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. & mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of NORINYL-1 (norethindrone 1 mg. with mestranol 0.05 mg.) in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with NORINYL-1. Therefore, if such tests are abnormal in a patient taking NORINYL-1 it is recommended that they be repeated after the drug has been withdrawn for two months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibromyomata may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. 5. NORINYL-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, and as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged NORINYL-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving NORINYL-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. 11. Because of the effects of estrogens on epiphyseal closure, NORINYL-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with NORINYL-1 may mask the onset of the climacteric. 13. The pathologist should be advised of NORINYL-1 therapy when relevant specimens are submitted.

Side effects observed in patients receiving oral contraceptives: The following adverse reactions have been observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weig (increase or decrease), changes in cervical erosion and cervical secretio suppression of lactation when given immediately postpartum, cholestati jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression.

Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, chang in libido, changes in appetite, cystiti like syndrome, headache, nervousn dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema no sum, hemorrhagic eruption, itchin

The following occurrences have be observed in users of oral contracep tives (a cause and effect relationshi has been neither established nor d proved): thrombophlebitis, pulmon embolism, neuro-ocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, Factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine a decrease in T^3 values), metyrapone test, pregnanediol determination.

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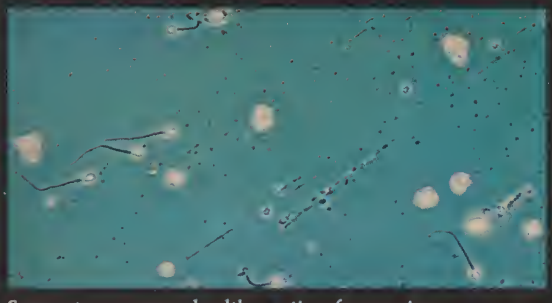
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

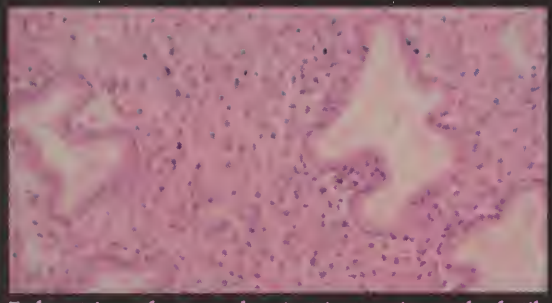
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.



Spermatozoa appear healthy, active, freemoving.

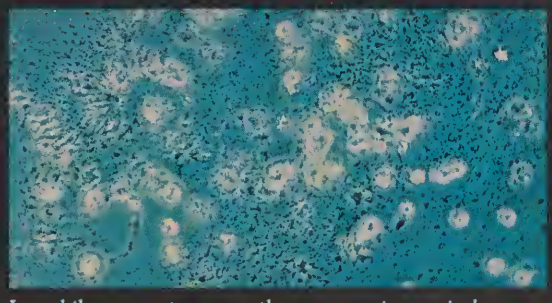


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

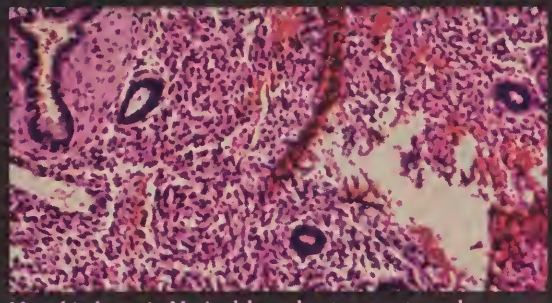
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



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fluocinolone acetonide





Turn page for contraindications, precautions and side effects.

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Product Information

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. *Precautions:* Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. *Side Effects:* Side effects are uncommon with topical corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. In such cases the agent should be discontinued and appropriate measures taken. *Availability:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Solution 0.01%—20 and 60 cc. plastic squeeze bottles. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream—5, 15 and 60 Gm. tubes.

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THE UNWED TEENAGE MOTHER

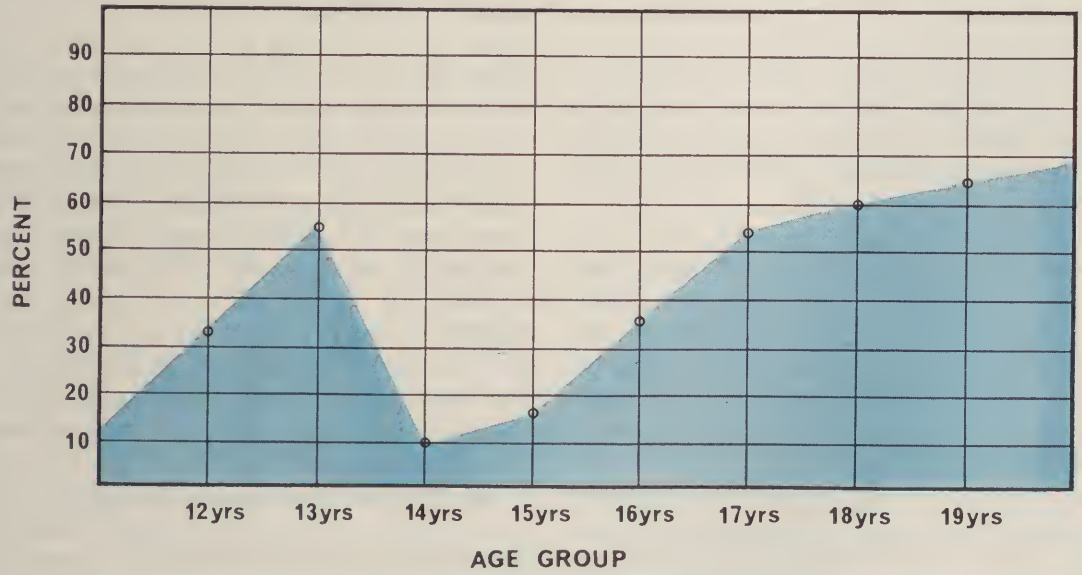
LOUIS RANDALL, MD

The pregnant teenager constitutes approximately 45% of all gestations in the city of Baltimore. By teenage pregnancy, one means all gestation ending before the 20th birthday. In Baltimore City, in 1964, there were 4,551 deliveries occurring to mothers from age 11 to 19.

It can be seen from studying the graph below, the greatest number of illegitimate babies are born to mothers from age 12 through 17, and a small decrease in illegitimacy occurs around age 18 to 19.

A more distressing factor is that the rate of illegitimacy is higher in the lower economic groups. One must remember, however, that quite often other economic groups shield their girls, therefore, no conclusive statistics are available for the overall pregnancy rate in all unmarried teenagers.

From available statistics, it is known that on a national level, the total number of illegitimate births in 1964 was 276,000 as compared to 176,000 in 1954. But the ratio of the number of births out of wedlock per every 1,000 unmarried women of child-bearing age has been fairly steady for the past decade. In fact, the rate has been plateaued or leveled off for the past seven years. Rates for



Study of Legitimacy of Live Births Born to Teenage Mothers in Baltimore in 1964.

teenagers have increased less than for other groups and for those under 15 years, the rate has not increased since 1947.

The factors leading to extramarital pregnancies are difficult to evaluate. In about 75% of patients seen (based on the author's experience) pregnancy followed naturally enough from the pursuit of adolescent practices normal to the whole society. It arose from a "deliberate choice of a mate, usually from the same occupational level, and from deliberate association with him. On the other hand, 25% of pregnancies resulted from such factors as rebellion against authority, a desire to punish a parent, or a reluctance to behave in a more conservative manner than contemporaries. A parent's excessive restraint or attitude toward sex may enhance the adolescent's effort to deny parental control, or wanting to be grown up and not feeling that he or she is, and wanting to take on the trappings of adult life and yet avoid its responsibilities. We find adolescents copying adults in their dress, staying out late, drinking, smoking, wanting a job and wanting to leave home, and experimenting in heterosexual behavior" according to Gallagher in *Medical Care of the Adolescent*. Furthermore, when the adolescent boy is struggling to emerge into the adult world he has his own misgivings and feels the heterosexual experience will settle doubts about his own masculinity.

In advanced societies, there is an attempt to impose so-called social childhood on youth. For example, keeping a child in school and ostensibly in subjection long past the age at which a child reaches physical maturity. When we consider it unnatural for young people between the ages of 15 and 20 to have sexual knowledge or experience, we have redefined childhood on a social rather than a physiological basis.

Our society envisions childhood ending, not at puberty with its dramatic physical termination, but at the completion of a prolonged educational experience or apprenticeship. The social children of our society have been physiological adults for years and we are upset because they behave according to their physiological state rather than conforming to our social definition.

An additional influence that has intensified problems of the teenager is that both sexes now reach puberty earlier than past generations. In 1858, the average age of the first menstruation was 17 years; in 1950, it had dropped to 13.7 years.

Also, in the teen years a strong sexual drive develops earlier in boys than in girls, the basis, perhaps, for the "double standard." There is little doubt the girl can more easily control the extent of heterosexual activity she will engage in. But from an anthropological point of view it is difficult to understand why, when they have the opportunity, most pubescents refrain from sexual intercourse. Many factors operate to control teenagers —there is their own self love, a possible fear of detection, pregnancy and disease, and in younger boys, their relationship to their mother acts as a taboo.

From observation of unwed teenage mothers in the Obstetrical Family Clinic of Sinai Hospital (Baltimore), it is interesting to note the lower the socio-economic class, the greater the chance for illegitimate birth, the greater the incidence of prematurity, and the greater the chance for toxemia (HBP, albuminuria, excessive weight gain).

The physician's function is to attempt to adjust any contributing factor such as doubts of femininity, feelings of unpopularity, rebellion, etc. and to offer support. Through gaining the girl's esteem, the physician can modify and enlarge her concept of a mature adult love relationship.

In the Sinai Clinic, the physicians use the multidisciplined approach to the problem of the unwed teenage mother with focus on the family as a basis for study and orientation of goals. Each patient seen in the Obstetrical Family Clinic receives the services of a team that includes two obstetricians for birth of the child and birth-control instructions; a resident doctor for pre- and post-natal care; a social worker for family counseling; a psychologist and a psychiatrist for group therapy; a pediatrician for child health care education; and public health nursing service which coordinates many of the activities mentioned.

Infants born of the Obstetrical Family Clinic are enrolled in the Pediatric Family Clinic. Maternal patients are interviewed, initially by a professional interviewer, and then approximately every 6 months for 3 years thereafter.

Whether the multidisciplined approach of the Sinai Clinic is the answer to the problem of preventing repetition of illegitimacy, remains to be seen.

State of Maryland
Department of Mental Hygiene

ISADORE TUERK, MD, COMMISSIONER
KURT GORWITZ, ScD, STATISTICS DIRECTOR

Retention And Release Rates Of Geriatric Admissions

Ten percent of all persons 65 years of age or older entering Maryland's mental hospitals died within four weeks after admission and mortality exceeded one-third within one year. An additional one-third were discharged or placed on long-term leave. The retention and release rates of the 931 geriatric patients admitted during the year ending June 30, 1965 are summarized in the following table.

	CUMULATIVE PERCENT			
Time Period	Died in Hospital	Discharged from Hospital	Placed on Long-term Leave	Percent in Hospital at End of each Period
Less than 7 Days	2.5	1.3	0.5	95.7
7–27 Days	9.9	6.0	3.1	81.0
1–3 Months	24.0	11.6	11.6	52.8
4–6 Months	29.0	12.7	15.0	43 3
7–11 Months	35.4	14.2	18.2	32.2
1–3 Years	47.4	16.2	22.6	13.8

Of these 931 patients, 47.4% have now died in the hospital, 38.8% have been discharged or placed on long-term leave with the remaining 13.8% still hospitalized. While many of the 301 released patients are now in the community or in nursing homes, some have died or have been rehospitalized.

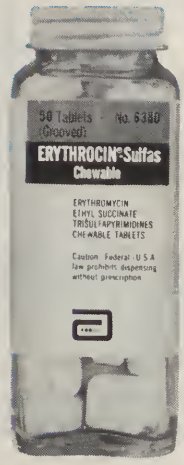
These data reflect a mortality rate very greatly exceeding comparable statistics for the general population which cannot be explained by socio-economic variations alone. They indicate that many of these older residents are admitted with concomitant major physical and mental illnesses and find the sudden transition from community to hospital traumatic. Four out of five had not previously been under psychiatric care and their current condition was diagnosed as primarily related to old age. As such, they raise dual questions regarding the propriety of accepting such individuals as mental hospital patients and the need for more appropriate community facilities.

Currently, 2,400 of the 7,800 patients in Maryland's mental hospitals (or 30% of the total) are geriatric. Primarily because of excess mortality among recent admissions, only 18.7% have been under care for less than one year. Conversely, 44.0% have been hospitalized continuously for 10 years or more. Most in this latter group were admitted at an earlier age for psychotic disorders and a significant reduction in their number is dependent on minimizing chronicity in hospitalized patients. The success of efforts to reduce the number of geriatric admissions is dependent primarily on providing alternative community based preventive and treatment programs. Of major importance is the establishment, expansion and improvement of state licensed and inspected nursing homes and the development of services in general hospitals for the treatment of concomitant physical and mental illnesses.



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Of the 55 patients, 30 were reported cured within 72 hours, while 22 showed partial recovery within the same time, and subsequent clinical cure.

A clinical cure rate of 94.5%

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87 patients were treated[1,2]—all children, ages four months to 15 years.

The diagnoses were multiple in some cases and were chiefly bacterial infections of the respiratory tract.

Dosage was maintained from three to 10 days; average treatment was five days. All of the ill children accepted the orange-flavored suspension favorably.

53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

701358

A clinical cure rate of 97.7%

1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

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Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

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Louis Krause, MD, Chairman
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RECENT ACCESSIONS

(Arranged by Subject)

Air Pollution

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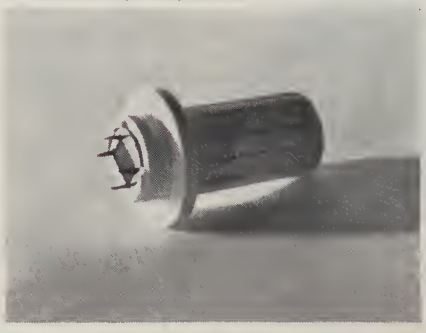
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Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

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Enduronyl: Its deserpidine component adds response in moderate hypertension



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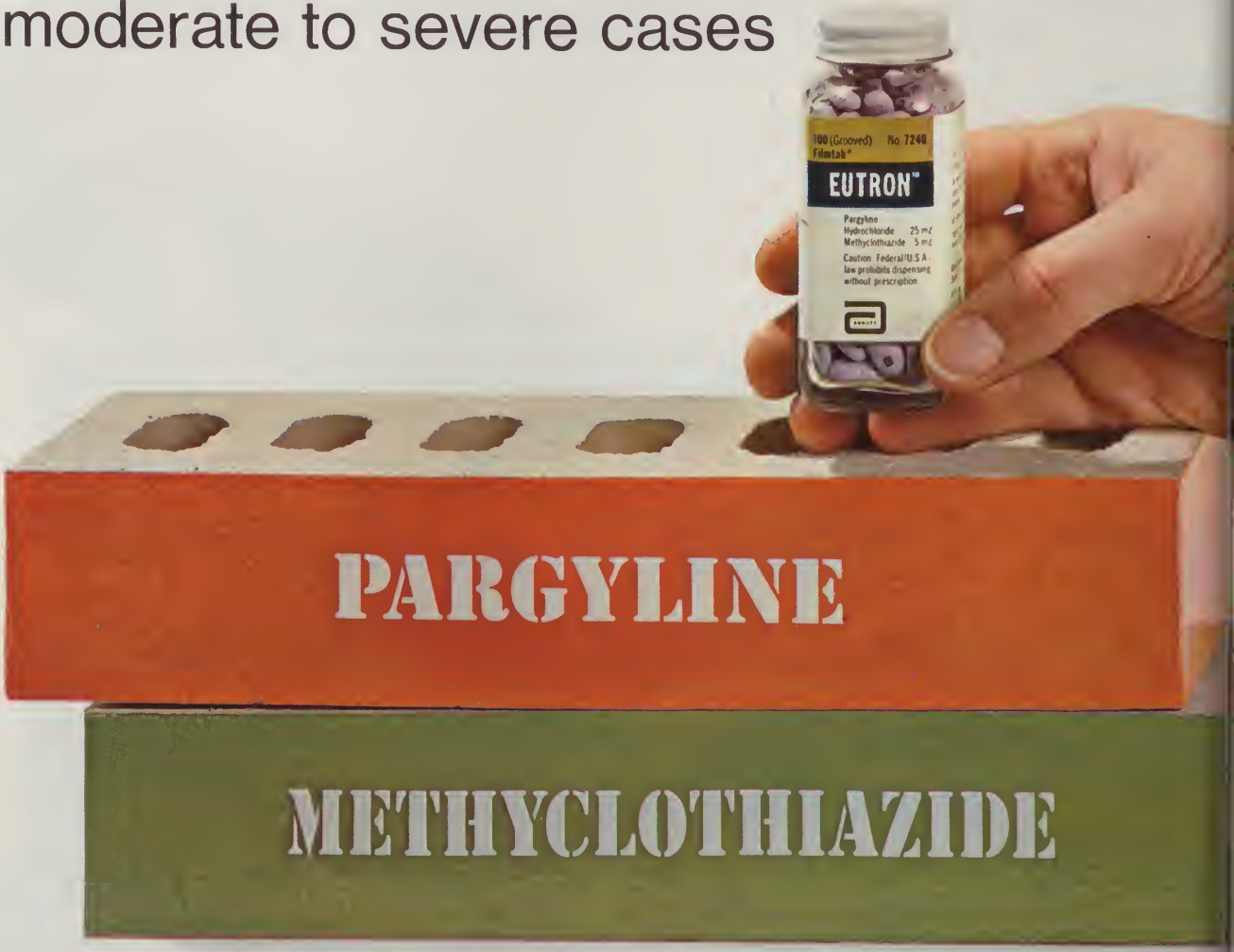
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Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

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MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

8010

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for patients with mild or labile hypertension amendable to therapy with sedatives and/or thiazide diuretics alone. It is desirable to establish the dosage of Eutron by administering component drugs separately.

Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery ¼ to ⅕ the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.

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Contraindications: History of sensitivity or severe intolerance to aspirin or meprobamate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with immediate gastric lavage and appropriate supportive therapy (CNS stimulants and pressor amines as indicated).

Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness. Overdosage may result in CNS depression (drowsiness and lightheadedness) or CNS stimulation and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]). Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically such as with epinephrine, antihistamine and possibly hydrocortisone. A few cases of leucopenia, usually transient, have been reported following continuous use. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.

A MESSAGE FROM THE IMMEDIATE PAST PRESIDENT OF THE BAMA

It has been a pleasure to have served as President of the Baltimore Association of Medical Assistants. The leadership is now in the capable hands of Eleanor Mainhart, CMA.

Being a charter member of the MAMA, there were many dreams for the BAMA and some of these have materialized. We have attained our goal of formal weekly educational classes and all of our meetings have been in keeping with the AAMA's concern over the 3 R's—RESEARCH —REFRESHERS—RETRAINING. We are also working on community service projects.

No President could accomplish any venture without good officers, committee chairmen and advisors. The loyalty, support and untiring effort on the part of the above have made the role of President very enjoyable, and for which I am deeply grateful. My sincere gratitude is also to the many physicians who have given so freely of their valuable time to speak at our monthly meetings.

The challenge of the role of the medical assistant in the field of medicine is increasingly mounting and the BAMA has accepted this challenge. My sincere hope is for continued growth and all the blessings and good wishes to the new officers.

Rita Cobry

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*FOXLEIGH	Garrison, Maryland	HU 6-4436
LAKE DRIVE	2401 Eutaw Place	669-4444
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DOCTORS, NURSES MEETING SET FOR WILLIAMSBURG, MARCH 11-13, 1968

The 14th annual combined Sectional Meeting for doctors and nurses sponsored by the American College of Surgeons will be held in Williamsburg, Va., March 11-13, 1968.

The first combined scientific program was presented in 1955 in Cleveland to provide a forum for the interchange of ideas and to help each group to keep abreast of technological and scientific advances. The meetings are similar in format and scope to the College's annual Clinical Congress.

The doctors' segment of the program will include presentations in general surgery and the following specialties: Gynecology - Obstetrics, Neurosurgery, Cardiovascular Surgery, Otorhinolaryngology, and Orthopedic Surgery.

Nurses discussions will focus on Patient Communications, Cryosurgery, Open-Heart Surgery, Clinical Specialists, Surgical Technicians, and other technical specialized procedures.

Medical films will be included in both programs.

David M. Hume, MD, Richmond, Va., is chairman of the surgeons' committee preparing the program for doctors. Mrs. Ina Love Williams, RN, Portsmouth, Va., heads the nurses' program committee.

Nurses and Fellows of the College may register at no charge. Other doctors will be assessed a registration fee of $15.00.

Program details and official hotel reservations forms may be obtained from College headquarters. Requests should be sent to: Mr. T. E. McGinnis, American College of Surgeons, 55 East Erie Street, Chicago, Illinois, 60611.

GENERAL SESSIONS
(Doctors Preliminary Program)

Monday, March 11

9-12 Noon	Presiding: Reed M. Nesbit, Ann Arbor, President, A.C.S.
9-9:30 A.M.	Motion Pictures.
9:30-10:45 A.M.	Panel: CLINICAL RENAL TRANSPLANTATION. Moderator: David M. Hume, Richmond. Panel: J. Hartwell Harrison, Boston. G. Melville Williams, Richmond. Leslie Rudolf, Charlottesville.
11-12 Noon	Papers. HEART TRANSPLANTATION. Richard R. Lower, Richmond. LIVER PERFUSION AND TRANSPLANTATION. William McDermott, Jr. REPLANTATION OF EXTREMITIES. Ronald A. Malt, Boston.
1:30-5 P.M.	Presiding: Charles J. Devine, Jr., Norfolk.
1:30-2 P.M.	Motion Picture.
2-3:30 P.M.	Panel: SURGICAL PROBLEMS OF PELVIC CANCER. Moderator: Irving F. Enquist, Brooklyn. Panel: George R. Prout, Jr., Richmond. William N. Thornton, Jr., Charlottesville. Edgar Boling, Atlanta.

3:45-5 P.M.	Papers. THE CLINICAL SIGNIFICANCE OF LOBULAR CARCINOMA INSITU OF THE BREAST. Edward F. Lewison, Baltimore. SELECTION OF PATIENTS IN SURGICAL TREATMENT OF NODULAR GOITER AND THYROID DISEASE. Colin G. Thomas, Jr., Chapel Hill. RECONSTRUCTION AFTER HEAD AND NECK CANCER SURGERY. Kenneth L. Pickrell, Durham.
Tuesday, March 12	
9-12 Noon	Presiding: William Allen Johns, Richmond.
9:30-11 A.M.	Panel: MANAGEMENT OF POSTGASTRECTOMY PROBLEMS Moderator: Walter Lawrence, Jr., Richmond. Panel: Edward R. Woodward, Gainesville. Theodore Drapanas, Pittsburgh. H. William Scott, Jr., Nashville.
11:15-12:30 P.M.	Papers. THE DIFFERENTIATION OF REGIONAL ILEOCOLITIS FROM MUCOSAL ULCERATIVE COLITIS. Rupert B. Turnbull, Jr., Cleveland. EXPERIENCE WITH THE THIERSCH WIRE IN RECTAL PROLAPSE. Robert V. Terrell, Richmond. THE ROLE OF CHOLANGIOGRAPHY IN THE MANAGEMENT OF COMMON DUCT OBSTRUCTION. Thomas N. P. Johns, Richmond.
1:30-5 P.M.	Presiding: William R. Sandusky, Charlottesville.
1:30-2 P.M.	Motion Picture.
2-3:30 P.M.	Panel: MANAGEMENT OF MULTIPLE ORGAN INJURIES Moderator: Curtis P. Artz, Charleston. Panel: G. Tom Shires, Dallas. Eugene F. Poutasse, Norfolk. Justus C. Pickett, Morgantown. James W. Brooks, Richmond.
3:45-5 P.M.	Papers. BURNS. Boyd W. Haynes, Jr., Richmond. TENDON REPAIR. Earle E. Peacock, Jr., Chapel Hill. CRYOTHERAPY IN OPHTHALMIC SURGERY. Herbert Wiesinger, Richmond.
Wednesday, March 13	
8:30-12 Noon	Presiding: Jacquelin M. Harrison, Richmond.
8:30-9 A.M.	Motion Picture.
9-10:30 A.M.	Panel: IMMEDIATE POSTOPERATIVE PROBLEMS Moderator: James D. Hardy, Jackson. Panel: Thomas F. Nealon, Philadelphia. (Pulmonary) (Anesthesia & Monitoring) Henry Thomas Randall, New York. (Fluid & Electrolytes) John Y. Templeton, III, Rosemont, Pa. (Cardio Vascular)
10:45-12 Noon	Papers. SEPTIC SHOCK. THROMBOEMBOLISM. David C. Sabiston, Jr., Durham. SURGICAL BLEEDING. Alexander W. Ulin, Philadelphia.

NEUROSURGERY

Monday, March 11

9-12 Noon — Presiding: William F. Meacham, Nashville.

9-9:30 A.M. — Motion Picture.

9:30-11 A.M. — Panel: CRANIOFACIAL RESECTION OF MALIGNANT TUMORS OF UPPER FACE, PARANASAL SINUSES AND EAR
Moderator: William F. Collins, Jr., Richmond.
Panel: J. M. Van Buren, Bethesda.
Jose J. Terz, Richmond.
Milton T. Edgerton, Jr., Baltimore.

11:10-12 Noon — Papers.
MID-BRAIN STEREOTACTIC LESIONS FOR RELIEF OF FACE, NECK AND ARM PAIN. Blain S. Nashold, Jr., Durham.
TRANSCRANIAL FRONTAL APPROACH TO THE ORBIT. Edgar M. Housepian, New York.

1:30-5 P.M. — Presiding: Guy L. Odom, Durham.

1:30-2 P.M. — Motion Picture.

2-3:30 P.M. — Panel: SURGERY OF THE PITUITARY GLAND
Moderator: Bronson S. Ray, New York.
Panel: Louis W. Conway, Richmond. (Results of Stereotactic Pituitary Surgery for Acromegaly)
Charles A. Fager, Boston. (Pituitary Surgery for Diabetes)
Bronson S. Ray, New York. (Transcranial Surgery of the Pituitary)

3:45-5 P.M. — Papers.
LOCAL HYPOTHERMIA FOR THERAPY OF ACUTE SPINAL CORD INJURY. Robert J. White, Cleveland.
SUBARACHNOID RISA AS A DIAGNOSTIC AID IN NEUROSURGERY. Maitland Baldwin, Bethesda.
EVALUATION OF TREATMENT OF GLIOBLASTOMA MULTIFORME. Richard K. Jelsma, Chicago.

CARDIOVASCULAR SURGERY

Monday, March 11

1:30-5 P.M. — Presiding: William H. Muller, Jr., Charlottesville.

1:30-2 P.M. — Motion Picture.

2-3:15 P.M. — Panel: SURGERY OF CORONARY ARTERY DISEASE.
Moderator: John H. Gibbon, Jr., Philadelphia.
Panel: William H. Sewell, Sayre. (Choice of Operation)
Julian Johnson, Philadelphia. (Internal Mammary Artery Implantation: Technique and Indications)
James H. Walker, Charleston. (Results of Internal Mammary Artery Implantation)

3:30-5 P.M. — Symposium: SURGERY FOR VALVULAR HEART DISEASE.
Moderator: Henry T. Bahnson, Pittsburgh.
Participants: John W. Kirklin, Birmingham. (Aortic Valve Homogra)
Frank C. Spencer, New York. (Prosthetic Replacement for Aortic Valve Disease)
Andrew Glenn Morrow, Bethesda. (Mitral Valve Replacement)
Charles A. Hufnagel, Washington. (Indications for Closed Operations or Plastic Repair of the Diseased Aortic and Mitral Valve)

OTORHINOLARYNGOLOGY

Tuesday, March 12

9:30-12:30 P.M. Presiding: Peter N. Pastore, Richmond.

9:30-10:30 A.M. How-I-Do-It-Clinic—IMPLANTS AS AN AID IN THE CORRECTION OF TRAUMA OR MALFUNCTION OF THE EAR, NOSE AND THROAT STRUCTURES.
Moderator: John E. Bordley, Baltimore.
Participants: John T. Dickinson, Pittsburgh. (Nasal-Sinus-Facial Complex)
Paul Ward, Nashville. (Velo-Palatine Dysfunction)
Godfrey Arnold, Jackson. (Laryngeal Malfunction)

10:30-10:45 A.M. Paper.
LARYNGEAL TRANSPLANTS—CURRENT STATUS. Joseph H. Ogura, St. Louis.

11-11:45 A.M. Panel: PROGRESS IN SURGICAL PROCEDURES FOR THE CONTROL OF PERSISTENT HEMORRHAGE—NOSE-LARYNX-TRACHEA.
Moderator: Francis H. McGovern, Danville.
Panel: Edwin N. Rise, Memphis.
James R. Chandler, Jr., Miami.
W. Franklin Keim, Montclair.

11:45-12:30 P.M. Papers.
CONTROL OF CHRONIC PAROTID SALIVARY GLAND DISEASE: THE MIDDLE EAR APPROACH. White M. Wallenborn, Charlottesville.
REPORT ON ALIMENTATION BY CERVICAL ESOPHAGOSTOMY. G. Slaughter FitzHugh, Charlottesville.

1:30-5 P.M. Presiding: Gordon D. Hoople, Syracuse.

1:30-2 P.M. Motion Picture.

2-3:15 P.M. Panel: MENIERE'S DISEASE—TRENDS AND SURGICAL TREATMENT.
Moderator: Gordon D. Hoople, Syracuse.
Panel: Raymond E. Jordon, Pittsburgh. (Thermocautery)
G. Douglas Hayden, Richmond. (Ultrasound)
Robert J. Wolfson, Philadelphia. (Cryotherapy)

3:30-4:45 P.M. Panel: REHABILITATION AFTER TOTAL LARYNGECTOMY.
Moderator: Joseph L. Goldman, New York.
Panel: Alden H. Miller, Los Angeles.
William W. Montgomery, Boston.
Douglas P. Bryce, Toronto.

4:45-5 P.M. Paper.
ELECTRONIC MECHANICAL AIDS FOR LARYNGECTOMY. Ann F. Flowers, Richmond.



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OBSTETRICS AND GYNECOLOGY

Tuesday, March 12

1:30-5 P.M. Presiding: Herbert A. Claiborne, Jr., Richmond.

1:30-2 P.M. Motion Picture.

2-3:30 P.M. Panel: GENITAL PROLAPSE AND URINARY INCONTINENCE.
Moderator: Robert Henry Barter, Washington.
Panel: Andrew A. Marchetti, Washington.
Buford Word, Birmingham.
Richard W. TeLinde, Baltimore.

3:45-5 P.M. Papers.

THE IMMUNOLOGIC PROBLEM OF PREGNANCY. Richard L. Simmons, New York.

MANAGEMENT OF POLYCYSTIC OVARY SYNDROME. Francis M. Ingersoll, Boston.

CHEMOTHERAPY IN THE MANAGEMENT OF DISSEMINATED GYNECOLOGIC CANCER. Henry Clay Frick, II, New York.

ORTHOPEDIC SURGERY

Wednesday, March 13

8:30-12 Noon Presiding: R. D. Butterworth, Richmond.

8:30-9 A.M. Motion Picture.

9-10:30 A.M. Panel: LOW BACK PAIN.
Moderator: Anthony F. DePalma, Philadelphia.
Panel: J. Alex Haller, Jr., Baltimore.
Frank J. Otenasek, Baltimore.
Robert C. Bunts, Richmond.

10:45-12 Noon Papers.

MANAGEMENT OF PATHOLOGICAL AND/OR IMPENDING PATHOLOGICAL FRACTURES. James A. Nicholas, New York.

LOWER EXTREMITY AMPUTATIONS—IMMEDIATE PROSTHESIS FITTING. Frank W. Clippinger, Durham.

FUNDAMENTAL PRINCIPLES OF THE CARE OF HAND INJURIES. Lee Ramsay Straub, New York.

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NURSES

Monday, March 11

9-12 Noon	Presiding: Ina Love Williams, Portsmouth, Chairman.
9-9:30 A.M.	Motion Picture: BUILDING TRAINING PROGRAMS FOR O.R. TECHNICIANS.
9:30-9:45 A.M.	Welcome: John Paul North, Chicago, Director, A. C. S.
9:45-10:15 A.M.	Paper: PULSE ON PATIENT COMMUNICATIONS. Sister Constancia Clark, Washington, D. C.
10:30-12 Noon	Panel: TEACHING PROGRAMS AND UTILIZATION OF SURGICAL TECHNICIANS. Moderator: Doris Armstrong, Baltimore. Panel: Juanita Bencoach, Charlottesville. Ann Fogarty, Portsmouth. Lucy Jo Atkinson, Somerville.
2-5 P.M.	Presiding: Norma Gardill, Portsmouth.
2-3:15 P.M.	Paper: ENDOSCOPY OF BRONCHIAL TREE. Jerry Cherry, Baltimore Motion Picture: ENDOSCOPY.
3:30-5 P.M.	Papers: THE ROLE OF THE CLINICAL SPECIALIST. Margaret Vaughn, Richmond. WE WERE THERE: PROJECT HOPE. Judy Buxton, Richmond. HOSPITAL SHIP REPOSE. Gerald L. Davis, Portsmouth.

Tuesday, March 12

9-12 Noon	Presiding: Mary Cibula, Richmond.
9-9:30 A.M.	Motion Picture.
9:30-10:45 A.M.	Papers: RENAL FAILURE. ACUTE RENAL FAILURE AND KIDNEY DIALYSIS. John Setter, Richmond. CHRONIC RENAL FAILURE AND RENAL TRANSPLANT. David M. Hume, Richmond. INFECTIONS OF URINARY TRACT. George R. Prout, Richmond.
11-12 Noon	Paper: NEW TRENDS IN CRYOSURGERY. William F. Collins, Richmond. Motion Picture: New Trends in Cryosurgery.
1:30-3:30 P.M.	Presiding: Sister Mary Jemma, Richmond.
1:30-2 P.M.	Motion Picture: I DRESS THE WOUND.
2-3:30 P.M.	Panel: HOSPITAL ACQUIRED INFECTIONS. Moderator: Doris Armstrong, Baltimore. Panel: William R. Sandusky, Charlottesville. George F. Mallison, Atlanta. Virginia Brown Melvin, Baltimore.

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Wednesday, March 13

9-12 Noon	Presiding: Ina Love Williams, Portsmouth.
9-9:30 A.M.	Motion Picture.
9:30-10:15 A.M.	Paper: NEW HORIZONS IN OPEN-HEART SURGERY. Richard R. Lower, Richmond.
10:30-12 Noon	Panel: POSTOPERATIVE MANAGEMENT OF THE SURGICAL PATIENT.
	Moderator: Norma Gardill, Portsmouth.
	Panel: Robert M. Campbell, Portsmouth. (Surgeon).
	Terring Heronimus, Charlottesville. (Anesthesiologist).
	Ann Rutherford, Charlottesville. (Nurse).
	Miriam G. Burgess, Norfolk. (Intensive Care Nurse).

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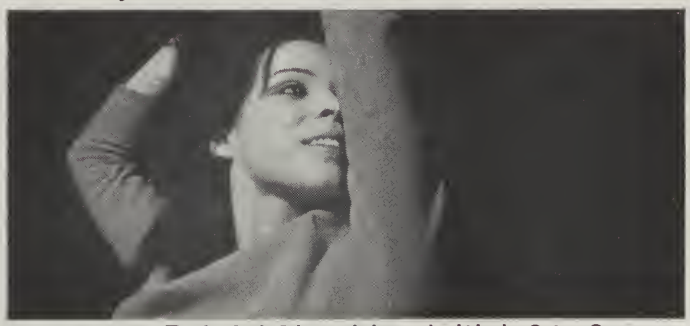
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Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.
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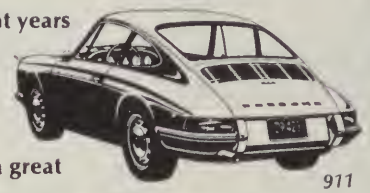
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MARCH 1—12:30 P.M.

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C. Thomas Flotte, MD, Associate Professor of Surgery, University of Maryland School of Medicine

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MARCH 8—12:30 P.M.

Making the Double Diagnosis: Or a New Look at History Taking

Ephraim T. Lisansky, MD, Associate Professor of Medicine and Psychiatry, University of Maryland School of Medicine

Sponsor: Sinai Hospital of Baltimore, Inc.

MARCH 15—12:30 P.M.

Diagnosis and Therapy of Hyperlipemic States

Simeon Margolis, MD, Assistant Professor of Medicine, The Johns Hopkins University School of Medicine

Sponsor: Anne Arundel General Hospital

MARCH 22—1:00 P.M.

Bacterial Endocarditis

Philip A. Tumulty, MD, Professor of Medicine, The Johns Hopkins University School of Medicine

Sponsor: Frederick Memorial Hospital

MARCH 29—12:30 P.M.

Cobalt Therapy in a Community Hospital

Albert P. Marsh, MD, Chief of Radiology, Sacred Heart Hospital

William R. Newman, MD, Radiologist, Sacred Heart Hospital

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(Heard at participating hospitals only)

TUESDAY MORNINGS—11:30 A.M.

MEDICAL GRAND ROUNDS
University of Maryland Hospital

FRIDAY AFTERNOON—2:00 P.M.

NEUROLOGY GRAND ROUNDS
University of Maryland Hospital

SATURDAY MORNINGS—8:00 A.M.

PEDIATRIC GRAND ROUNDS
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(See pages 8 and 9 for more information)

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NOTICES OF GENERAL INTEREST

Occupational Health:

The Occupational Health Committee, at its meeting of January 17, 1968, considered Council's letter of September 14, 1967 concerning adoption of Liaison Committee's recommendations. The following motion was passed:

> The Occupational Health Committee of the Medical and Chirurgical Faculty of Maryland supports the principle that industry requiring pre-employment chest X-rays should be encouraged to contract with a private Radiologist whenever possible. The Health Department and the Maryland Tuberculosis Association should discourage the use of their facilities by industry for pre-employment X-rays where it is felt that such an arrangement with a private Radiologist is feasible.

* * * *

Massachusetts General Seeks Information:

A committee of the Massachusetts General Hospital is studying the hospital's records and world literature to determine pertinent features in all patients who, *despite coma for over five weeks,* have made a useful recovery.

The committee feels that it is vital not to overlook any well-documented patient in this category and would appreciate being informed of any case published under a title which is not indicative of survival after prolonged coma, as well as accounts of such cases as yet unreported, for incorporation in a publication.

Contact: William H. Sweet, MD, DSc
Chief, Neurosurgical Service
Chairman, Committee on Management of the Unconscious Patient
Massachusetts General Hospital
Boston, Massachusetts 02114

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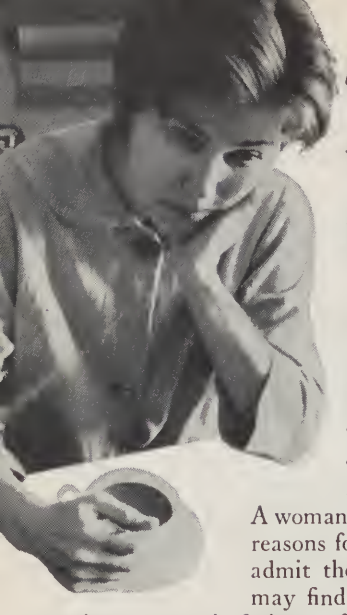
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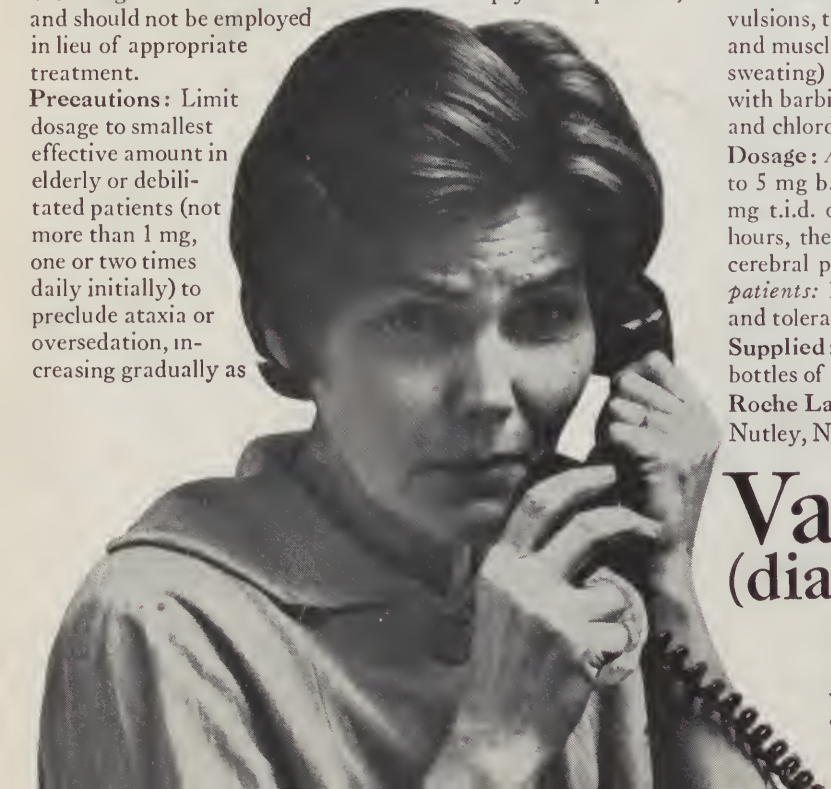


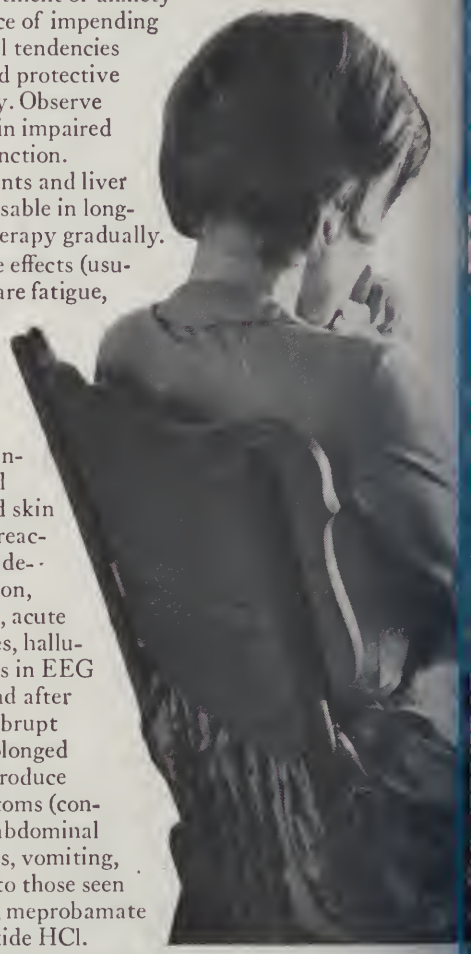
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Precautions: Limit dosage to smallest effective amount in elderly or debilitated patients (not more than 1 mg, one or two times daily initially) to preclude ataxia or oversedation, increasing gradually as needed or tolerated. As is true of all CNS-acting drugs, until correct maintenance dosage is established, advise patients against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. If such combination therapy is used, carefully consider individual pharmacologic effects–particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants. Advise patients against simultaneous ingestion of alcohol or other CNS depressants. Safe use in pregnancy not established. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.





Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

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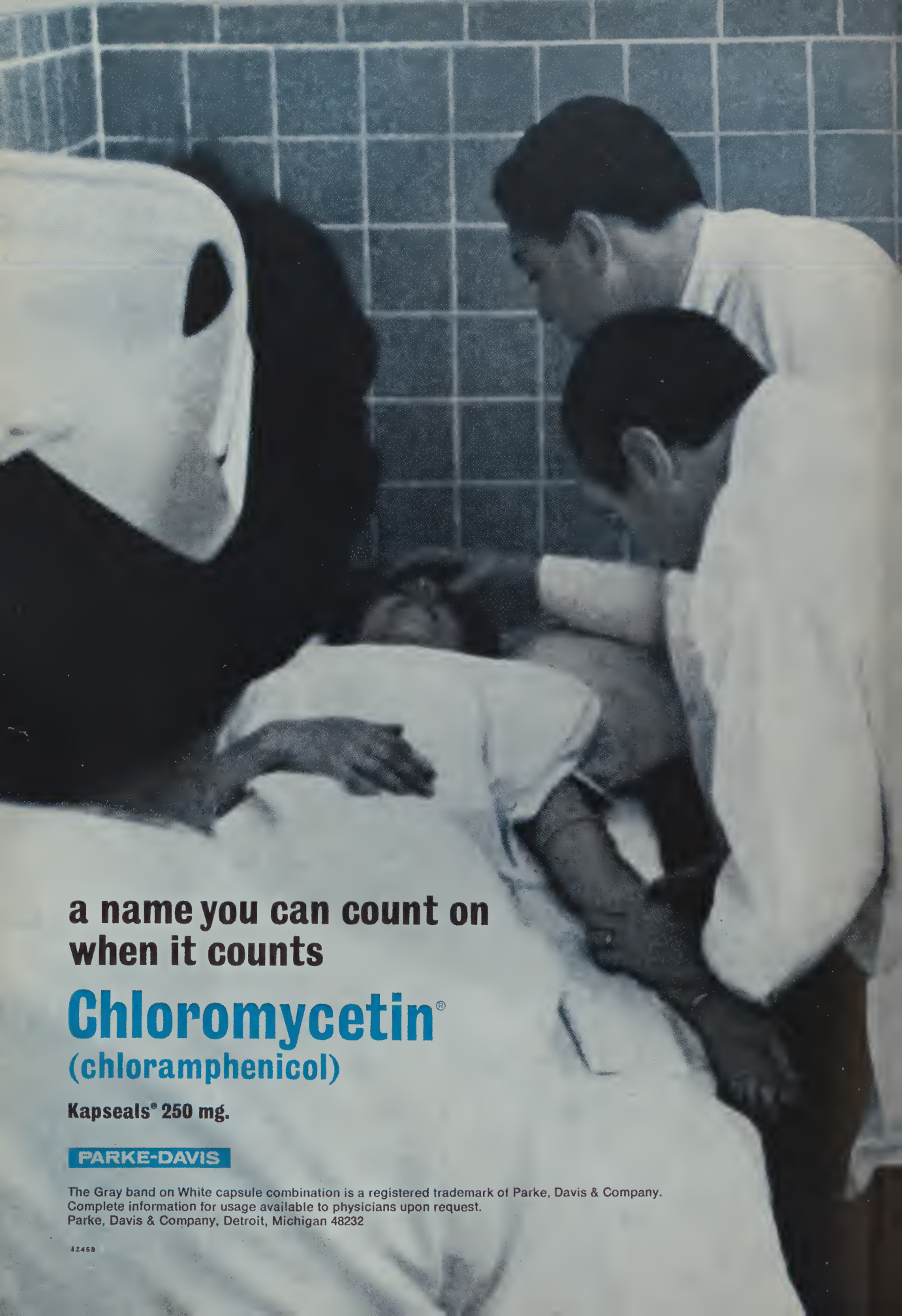
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Precautions—Overgrowth of nonsusceptible organisms may occure. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth— dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs. foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm. given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

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Joint Meeting, 8:15 P.M.: Osler Hall, Medical-Chirurgical Faculty of Maryland, 1211 Cathedral St., Baltimore, Md. Speaker: David E. Rogers, MD, Professor and Chairman of the Department of Medicine, Vanderbilt University Medical School and Hospital, and newly appointed Dean of the Faculty and vice president (medicine) of The Johns Hopkins University School of Medicine and Medical Director of The Johns Hopkins Hospital.

MARCH 27, 1968
SUMMIT COUNTY DIABETES ASSOCIATION
Postgraduate Seminar—Diabetes Mellitus: Holiday Inn, 200 East Exchange St., Akron, Ohio. Moderator: Harvey C. Knowles, Jr., MD, Professor of Medicine, University of Cincinnati College of Medi- and President-Elect of the American Diabetic Association. Contact: I. R. Rosenberg, MD, chairman, Diabetes Seminar, 513 West Market St., Akron, Ohio 44303.

MARCH 27, 1968
MARYLAND ACADEMY OF OPTHALMOLOGISTS
Meeting: Linden Hill Hotel, Bethesda, Md. Speaker: Mr. Dick Porter, Chairman, Montgomery County Special Education Section.

MARCH 28, 1968
LABORATORY OF CLINICAL INVESTIGATION, NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES
Clinical Staff Conference, 8:30 P.M.: Clinical Center Auditorium, NIH, Bethesda, Md. Moderator: Sheldon M. Wolff, Acting Clinical Director, NIAID.

MARCH 29-31, 1968
AMERICAN SOCIETY OF INTERNAL MEDICINE
12th Annual Meeting: Hotel Statler, Boston, Mass. Contact: Mr. Edward E. Daleske, Assistant Executive Director, American Society of Internal Medicine, 3410 Geary Blvd., San Francisco, Calif.

APRIL 1-5, 1968
AMERICAN COLLEGE OF PHYSICIANS IN ASSOCIATION WITH THE ROYAL COLLEGE OF PHYSICIANS OF LONDON
49th Annual Session: Sheraton-Boston Hotel, Boston, Mass. Meetings: War Memorial Auditorium. General Chairman: Daniel S. Ellis, MD, FACP. Contact; ACP Housing Bureau, c/o Greater Boston Chamber of Commerce, 125 High St., Boston, Mass. 02110.

APRIL 4-6, 1968
AMERICAN MEDICAL ASSOCIATION, DEPARTMENT OF HEALTH EDUCATION
3rd National Conference—Health Education and Health Care Services: Pick Congress Hotel, Chicago, Ill. Contact: Department of Health Education, American Medical Association, 535 N. Dearbron St., Chicago, Ill. 60610.

APRIL 5-6, 1968
AMERICAN MEDICAL ASSOCIATION, COMMITTEE ON DISASTER MEDICAL CARE OF THE COUNCIL ON NATIONAL SECURITY AND THE MEDICAL SOCIETY OF NORTH CAROLINA
23rd Regional Conference: Duke University Medical Center, Durham, N. C. Requests for hotel Reservations should be sent directly to: Statler-Hilton Hotel, Durham, N. C. Contact: Committee on Disaster Medical Care, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610.

APRIL 8-10, 1968
HAHNEMANN MEDICAL COLLEGE AND HOSPITAL
Postgraduate Course—Pre- and Post-Operative Management of the Cardiopulmonary Patient: Marriott Motor Hotel, Philadelphia, Pa. Director: Joseph F. O'Malley, MD, Wilbur W. Oaks, MD. Contact: Sage Rosen, Assistant Director, Postgraduate Education, Hahnemann Medical College and Hospital, Dept. of Medicine, 230 N. Broad St., Philadelphia, Pa. 19102

APRIL 10-11, 1968
ALUMNI ASSOCIATION OF THE UNIVERSITY OF MARYLAND SCHOOL OF SOCIAL WORK, THE MARYLAND CHAPTER OF NASW, AND THE SCHOOL OF SOCIAL WORK
Conference on social implications of comprehensive health services: Sheraton-Belvedere Hotel, Baltimore, Md. Contact: Mrs. Gertrude L. Nilsson, ACSW, 383-3010, ext. 8630 in Baltimore.

APRIL 11-13, 1968
THE MOUND PARK HOSPITAL FOUNDATION, ST. PETERSBURG, FLA.
Postgraduate Course—Correlations in Medicine; The Clinician and the Laboratory: Teaching Auditorium, Mound Park Hospital. Contact: Correlations in Medicine, Mound Park Hospital Foundation, Inc., 701 Sixth Street South, St. Petersburg, Fla. 33701.

APRIL 17-20, 1968
AMERICAN COLLEGE OF SURGEONS, CHICAGO COMMITTEE ON TRAUMA
12th Annual Postgraduate Course in Fractures and other Trauma: John B. Murphy Memorial Auditorium, 50 East Erie St., Chicago, Ill. Director: Colman J. O'Neill, MD. Contact: James P. Ahstrom, Jr., MD, Chairman, 12th Postgraduate Course in Fractures and other Trauma, American College of Surgeons, 55 E. Erie St., Chicago, Ill. 60611.

APRIL 26, 1968
MID-ATLANTIC STATES SECTION AIR POLLUTION CONTROL ASSOCIATION
Semi-Annual Technical Conference—The Legal Road to Clearer Air: Gold Ballroom, Hotel Dupont, 11th St. at Market, Wilmington, Dela. Contact: Reuben Wasser, Treasurer, Middle Atlantic States Section, APCA, Public Service Electric and Gas Co., 200 Boyden Ave., Maplewood, N. J. 07040. (Orders for advance registration must be received by April 10, 1968.)

CARIBBEAN CRUISE CONVENTION
SUNDAY, APRIL 21 TO SUNDAY, APRIL 28, 1968

Sunday, April 21	Sail from Baltimore at approximately 4:00 P.M.
Monday, April 22 and Tuesday, April 23	**Scientific sessions** and **films aboard ship,** with time for fun - sunning, swimming, entertainment, dancing, movies, and excellent food
Wednesday, April 24	**Scientific session** and **film** in A.M. Arrive San Juan about 1:00 P.M.
Thursday, April 25	Arrive in St. Thomas about 9:00 A.M.
Friday, April 26 and Saturday, April 27	**Scientific sessions** and **films aboard ship,** with time for fun as noted above
Sunday, April 28	Arrive in Baltimore about 2:00 P.M.

For Cruise Convention reservations contact: Travel Guide Agency Ltd., 416 North Charles Street Baltimore, Maryland 21201 (Telephone: SAratoga 7-1696)

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Turn page for contraindications, precautions and side effects.

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Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. *Precautions:* Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. *Side Effects:* Side effects are uncommon with topical corticosteroids As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. In such cases the agent should be discontinued and appropriate measures taken. *Availability:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Solution 0.01%—20 and 60 cc. plastic squeeze bottles. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream—5, 15 and 60 Gm. tubes.

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Reserve now for the Scientific Awards Dinner in honor of the Scientific Award Winners—Wednesday, June 19, 1968. Since space is limited, we suggest you make your reservations before June 3, 1968. Tickets are $10.00 each, payable in advance.

The complete scientific program, plus forms for advance registration and hotel accommodations, will be featured in JAMA, May 6, 1968.

SAN FRANCISCO, CALIFORNIA · JUNE 16-20, 1968

AMERICAN MEDICAL ASSOCIATION'S 117th ANNUAL CONVENTION · BROOKS HALL

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Tables: Each table should be typed on a separate sheet of paper, be numbered consecutively, have a brief descriptive title, and its position in text indicated. Take care that columns add up correctly and that statistics are consistent in both tables and text.

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OPEN LETTER

Dear Doctor:

I am writing to introduce myself as the new Managing Editor of the MARYLAND STATE MEDICAL JOURNAL and to extend my personal invitation to you to participate in the editorial affairs of this journal.

At the moment, I am working toward two futures—the immediate and the not-too distant.

At present, there is an exceptional opportunity for you to have your scientific papers published in the JOURNAL. Our Editor, Dr. Flotte, would be most pleased to receive and consider your manuscripts.

Also, we would appreciate any suggestions you might have as to how we could serve you better. The staff of the JOURNAL feels a genuine obligation to provide a literary platform for you and your fellow physicians engaged in socio-medical, as well as, scientific studies and programs, and to encourage the use of our journal facilities as a spokesman for your efforts in areas of interest to you.

We look forward to hearing from you.

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EXECUTIVE SECRETARY'S NEWSLETTER

March, 1968

ANNUAL MEETING

Hotel reservations for the Faculty's Annual Meeting should be made at the Sheraton-Belvedere, where a block of 50 rooms has been set aside for Faculty members and their guests.

One of the highlights of the Annual Meeting will be the Presidential Dinner, where Art Buchwald, Syndicated Columnist, will talk on "Son of the Great Society."

Full details of all activities can be found in the Annual Meeting program, which will be in the mail within the next few days.

NEWS NOTES

Robert M. Barnett, M.D., Baltimore, has received board certification in Obstetrics and Gynecology.

Richard E. Hoover, M.D., was honored at a dinner meeting of the Board of Directors, Maryland Society for Prevention of Blindness, recently. He has served on the Board since 1955 and was President since 1959.

At the same meeting, Howard A. Naquin, M.D. was elected President; while John B. Saratsiotis, M.D., was named to the Board. Others serving on the Board include Angus L. McLean, M.D., Arnall Patz, M.D., and Richard D. Richards, M.D.

New Diplomates of the American Board of Anesthesiology include: Roberto S. Garcia, M.D., Oscar Kantt, M.D., and Sylvia Sussman, M.D., of Baltimore; and Theodore W. Striker, M.D. and Sergei L. Snegireff, M.D., of Bethesda.

X-RAY POLICIES

The Faculty's Occupational Health Committee has indicated its support of the policy that industry requiring pre-employment chest x-rays should be encouraged to contract with a private Radiologist, wherever possible.

X-RAY POLICIES (cont'd)

It also stated its endorsement of the policy that Health Department and Maryland Tuberculosis Association facilities should discourage the use of such services for pre-employment x-rays.

AMA PRESIDENT'S COMMENTS

Charles L. Hudson, M.D., while President of the AMA, had some cogent remarks to make regarding the financing of health services.

"It is an area where decisions need to be made - where responsibility needs to be exercised. It is also an area fraught with pitfalls. There are hazards associated with anything we do or what we may fail to do. The hazards of omission, in my estimate, are infinitely greater than the dangers of commission."

PERSONALITIES

Newly named to the Committee on Medicine of The Professional Forum are Henry L. Wollenweber, M.D., Raymond L. Markley, M.D., and Ray Beasley, M.D.

AMA QUESTIONNAIRE

The March 18 issue of AMA News will include a Physician Activity Verification Questionnaire which should be completed and returned to the AMA. Your cooperation is asked in completing and returning this questionnaire.

RETIREMENT PLAN

The Med-Chi Members Retirement Plan has been approved by the Internal Revenue Service. The IRS serial number is PGH: POL:68-26.

Participants in the plan may obtain a written determination as to the qualification of the plan under Section 401 (a) of the IRS Code by filing Form 3673 with their local District Director. The Plan name and serial number as shown above should be indicated on the form.

John Sargent

Executive Secretary

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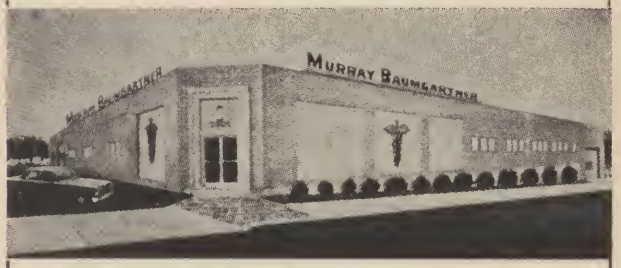
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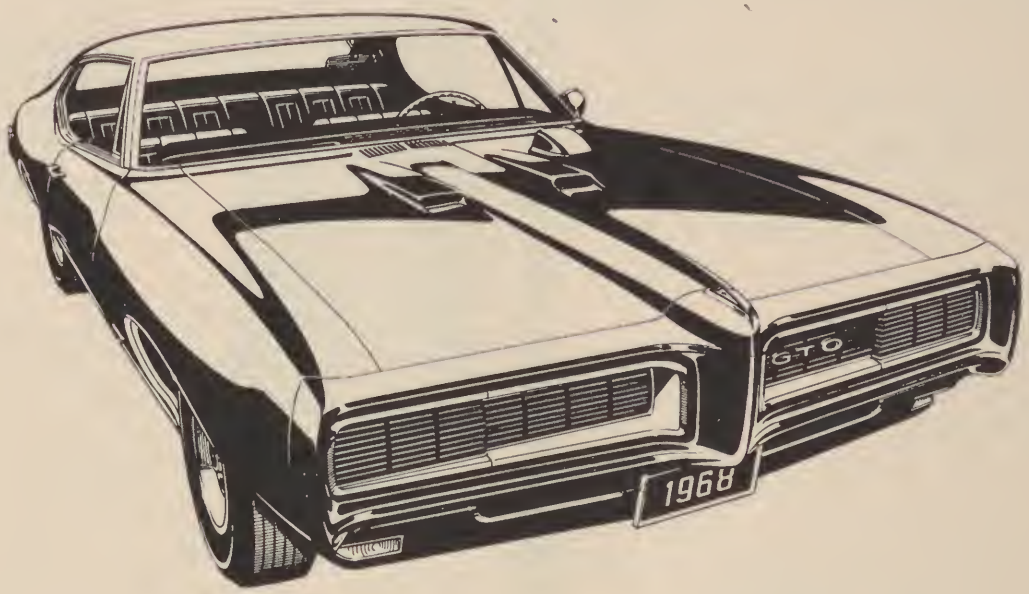
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When you start with economical Tetrex-F (tetracycline phosphate complex-nystatin), you can complete the full course of broad-spectrum therapy with less chance of losing control elsewhere. A good start for a healthy finish.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

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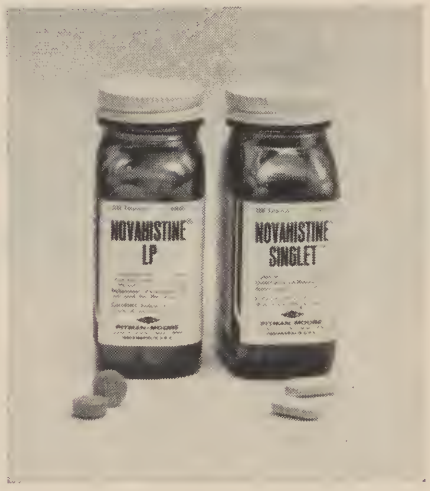
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Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

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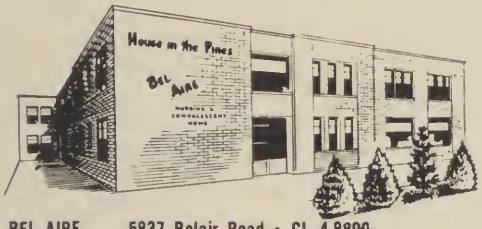
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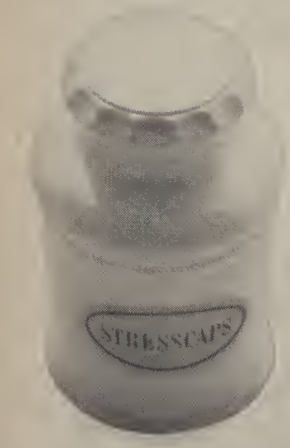
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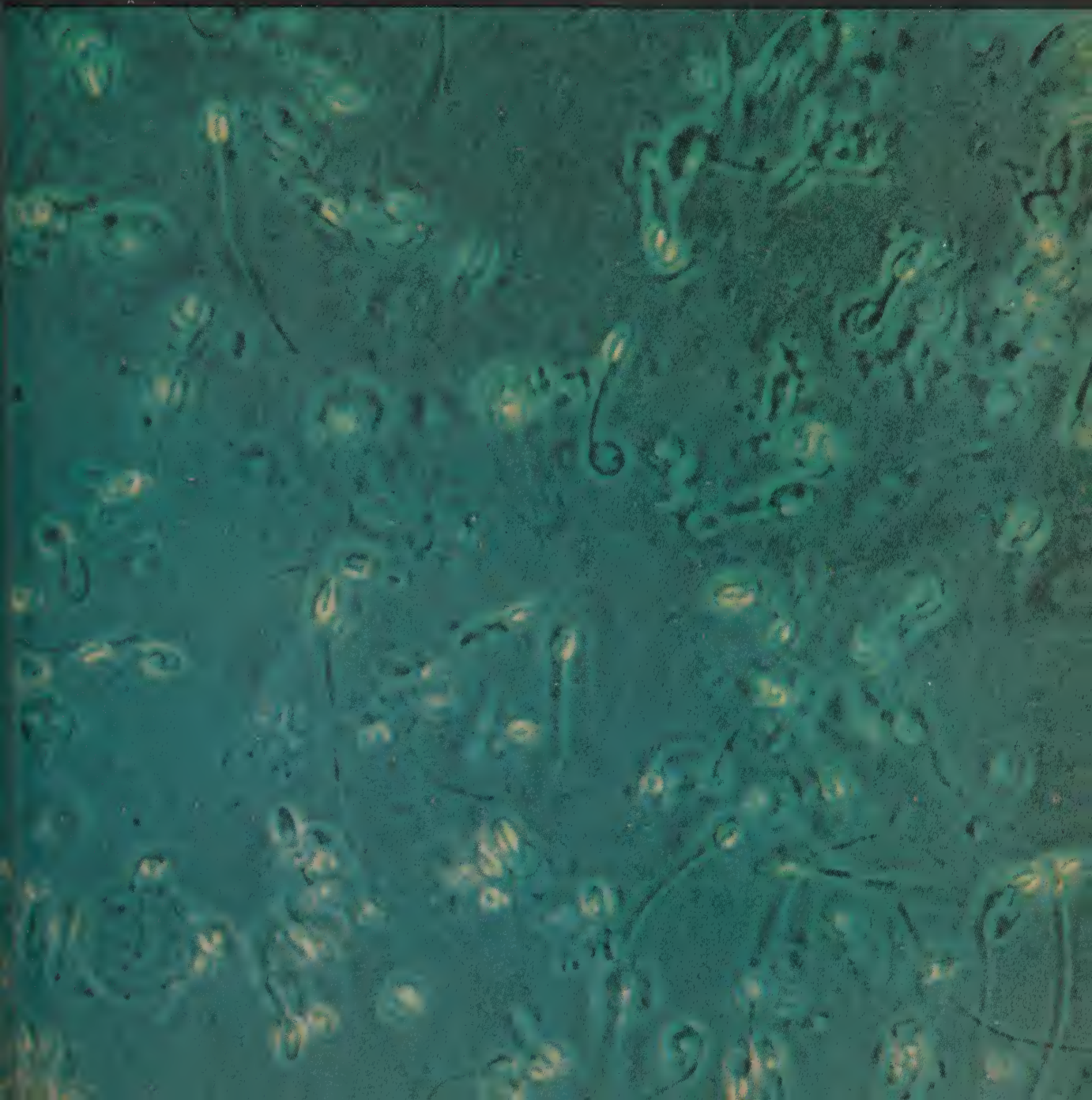
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Turn page for contraindications, precautions and side effects.



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What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of NORINYL-1 (norethindrone 1 mg. with mestranol 0.05 mg.) in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with NORINYL-1. Therefore, if such tests are abnormal in a patient taking NORINYL-1 it is recommended that they be repeated after the drug has been withdrawn for two months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibromyomata may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. 5. NORINYL-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, and as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged NORINYL-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving NORINYL-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. 11. Because of the effects of estrogens on epiphyseal closure, NORINYL-1 should be used judiciously in young patients in whom bone growth is not complete. 12. Th age of the patient constitutes no absolute limiting factor, although treatment with NORINYL-1 may mask the onset of the climacteric. 13. The pathologist should be advised of NORINYL-1 therapy when relevant specimens are submitted.

Side effects observed in patients receiving oral contraceptives: The following adverse reactions have been observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (su as abdominal cramps and bloating) breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlarge ment and secretion), change in wei (increase or decrease), changes in cervical erosion and cervical secreti suppression of lactation when give immediately postpartum, cholestat jaundice, migraine, rash (allergic), rise in blood pressure in susceptibl individuals, mental depression.

Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, chang in libido, changes in appetite, cystit like syndrome, headache, nervousn dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema no sum, hemorrhagic eruption, itchin

The following occurrences have be observed in users of oral contracep tives (a cause and effect relationshi has been neither established nor d proved): thrombophlebitis, pulmon embolism, neuro-ocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, Factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine a decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from
SYNTEX
LABORATORIES INC., PALO ALTO, CALIF

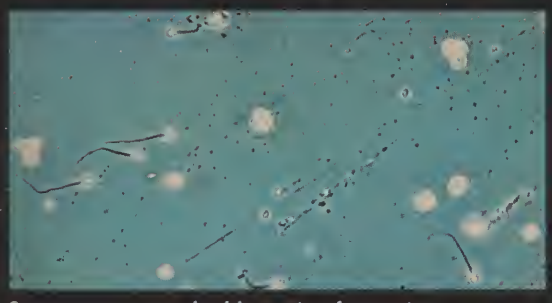
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

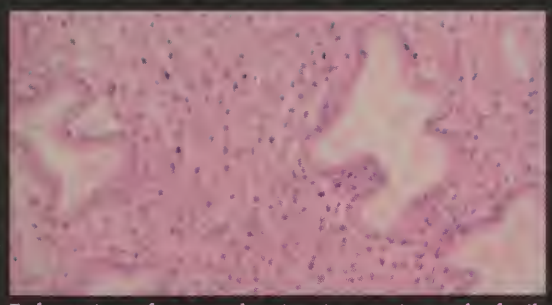
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.



Spermatozoa appear healthy, active, freemoving.

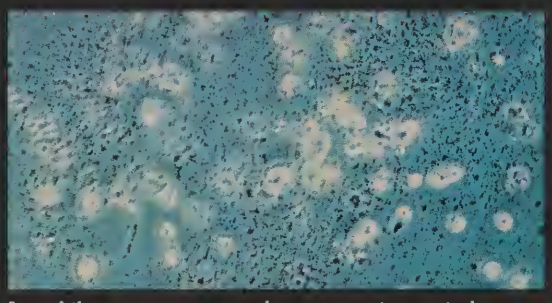


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

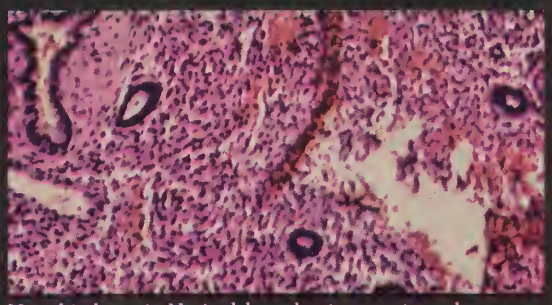
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

Norinyl®-1
(norethindrone 1mg. & mestranol 0.05mg.) tablets

- new low dose of time-proved ingredients
- established norethindrone/mestranol ratio
- lower patient cost

Night Leg Cramps . . . Unwelcome Bedfellow

In Diabetes[1], Arthritis[2], and Peripheral Vascular Disorders[2]



now . . . specific therapy for night leg cramps

Walker

QUINAMM™

Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchanism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rowls, W., et al.: Med. Times, 87:818, 1959.

6/67 Q-706A



"The inconvenience of a cold"

For a cold, NTz® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTz is well tolerated but overdosage should be avoided.

As sinusitis deterrent, NTz Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

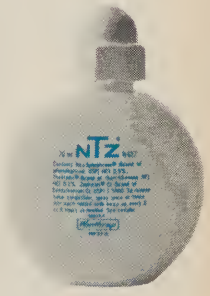
Supplied: NTz Nasal Spray, plastic squeeze bottles of 20 ml.; NTz Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

NTz is more than a simple vasoconstrictor. It contains

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.



Winthrop Laboratories, New York, N.Y. 10016 Winthrop

Valium® (diazepam) useful adjunct for the coronary patient...

When oppressive feelings and psychic tensions are severe and cooperation with the physician poor, it may be helpful to add adjunctive Valium (diazepam), 10 mg or 5 mg t.i.d., to the coronary patient's regimen. Valium (diazepam) helps to promote the needed relaxation that the patient requires to make him less preoccupied with his condition and more inclined to cooperate in, and benefit from, the total therapeutic program. Valium (diazepam) may be administered in the presence of secondary depressive symptoms.

in the hospital...

(5 mg. or 10 mg t.i.d.)

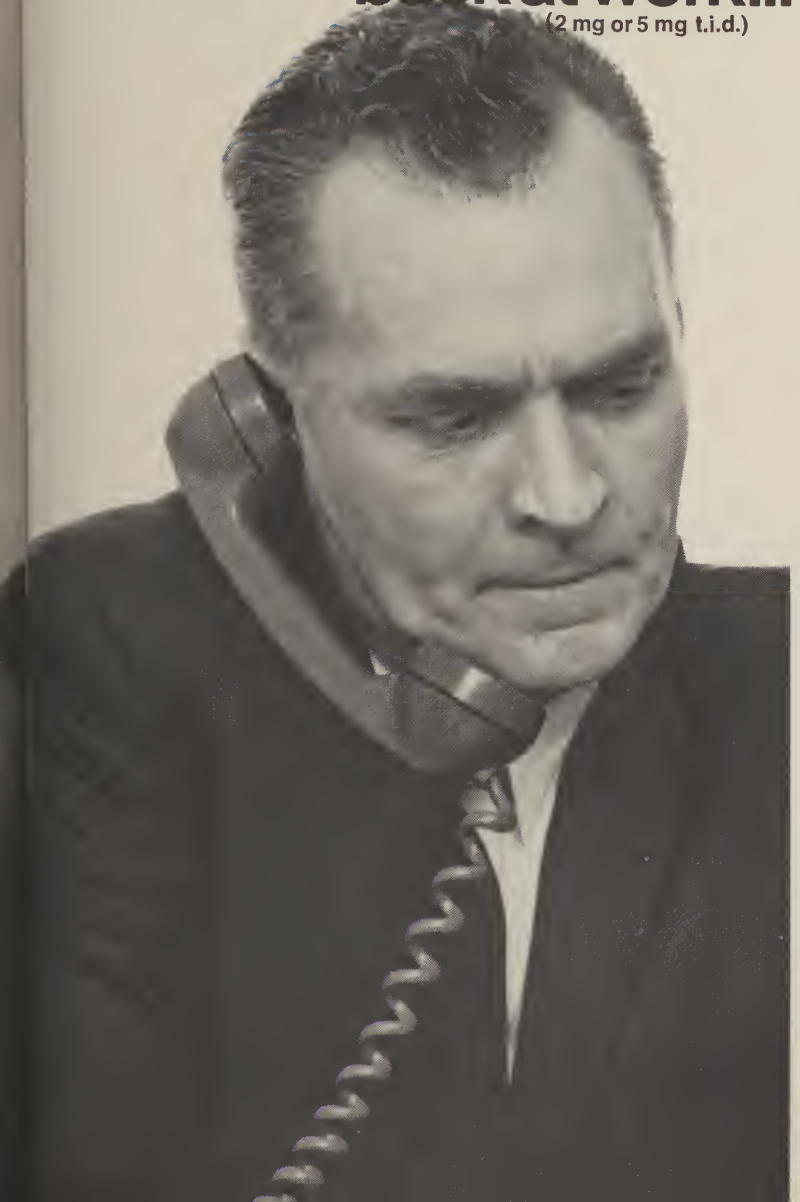


convalescing...
(2 mg or 5 mg t.i.d.)

The heart patient who leaves the hospital to enter a period of slow restorative treatment is often forced to make emotionally difficult adjustments. The resulting stress of this period may again cause psychic tension to mount to potentially harmful levels. To augment your reassurance and the emotional support of his family, a 2 mg or 5 mg t.i.d. regimen of Valium (diazepam) can reduce psychic tension and thereby help the patient to accept necessary restrictions more calmly, and to adjust to his illness more realistically.

Getting back to work presents additional stresses for the cardiac patient. There are often anxiety-producing features in the job which can be more significant than the physical or intellectual demands of the work. Valium (diazepam), 2 mg or 5 mg t.i.d., may be a useful adjunct to reduce overreaction to these stresses and thus help the patient to face job situations more calmly and rationally.

back at work...
(2 mg or 5 mg t.i.d.)



Valium® (diazepam)
to help relieve psychic tension

and for the patient with tension-induced sleeplessness, remember the value of an extra tablet at bedtime

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states, moderate to severe psychoneurotic states with anxiety, apprehension or agitation alone or with depressive symptoms; somatic complaints which are concomitants of emotional factors; acute agitation due to alcohol withdrawal; muscle spasm associated with cerebral palsy and athetosis.

Contraindications: Infants, patients with history of convulsive disorders, glaucoma or known hypersensitivity to drug.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly or debilitated patients (not more than 1 mg, one or two times daily initially) to preclude ataxia or oversedation, increasing gradually as needed or tolerated. As is true of all CNS-acting drugs, until correct maintenance dosage is established, advise patients against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. If such combination therapy is used, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants. Advise patients against simultaneous ingestion of alcohol or other CNS depressants. Safe use in pregnancy not established. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

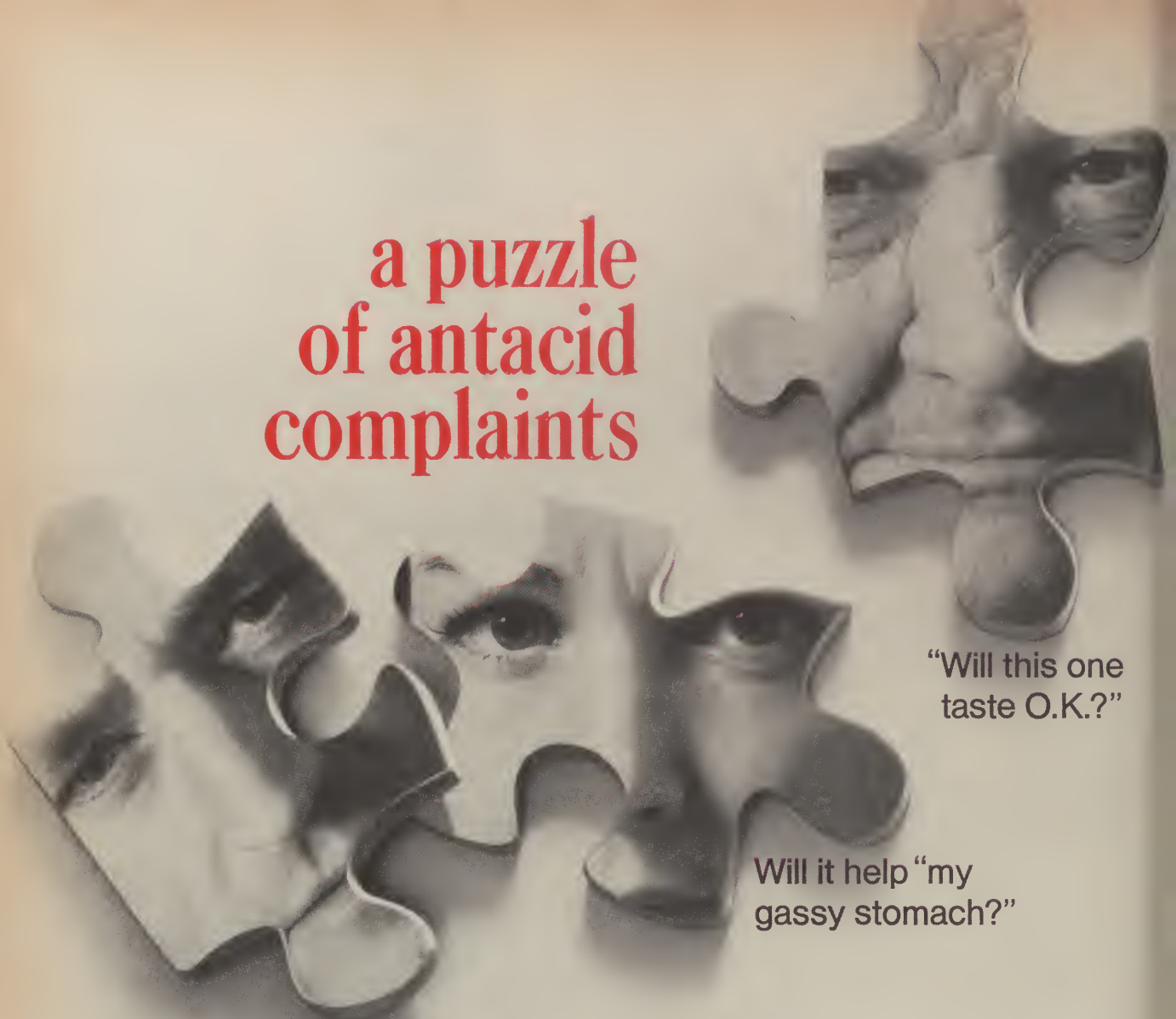
Dosage—Adults: Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d.

Geriatric patients: 1 or 2 mg/day initially, increase gradually as needed and tolerated. (See Precautions.)

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50 and 500.

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

a puzzle of antacid complaints



Mylanta®

aluminum and magnesium hydroxide *plus* simethicone

a solution to peptic ulcer distress

Effective neutralization—
with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

Concomitant relief of G.I. gas distress—
with the proven[1] defoaming action of simethicone.

Prolonged acceptance confirmed—
in 87.5% of 104 patients after a total of 20,459 documented days of therapy.[2]

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

References: 1. Hoon, J.R.: Arch. Surg. *93*:467 (Sept.) 1966.
2. Danhof, I.E., Personal communication.

Stuart
Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.



helps restore normal motility and tone

CANTIL®

(mepenzolate bromide)

Diarrhea and other symptoms of common G.I. disorders can often be curbed with Cantil (mepenzolate bromide), bringing welcome relief to the harassed patient. Relatively specific for the hyperactive colon, it helps reduce diarrhea, pain and spasm with minimal effect on other viscera. Cantil (mepenzolate bromide) is indicated whenever these symptoms are associated with irritable colon, gastroenteritis, diverticulitis, and mild to moderate ulcerative colitis.

It is an anticholinergic drug without narcotic properties. Side effects are usually mild.

LAKESIDE

CONTRAINDICATIONS: Sensitivity to Cantil® (mepenzolate bromide), glaucoma, G.I. or G.U. obstruction, toxic megacolon. WARNINGS: Possibility of adverse reactions in advanced severe ulcerative colitis and atypical agitated reactions to phenobarbital in the elderly (Cantil with Phenobarbital). PRECAUTIONS: Cantil is of adjunctive use only; treatment of the underlying condition is indicated, be it organic or functional. Observe caution in conditions known to be incompatible with atropine-like drugs, e.g., open-angle glaucoma or prostatic hypertrophy. ADVERSE EFFECTS: Dry mouth; blurred vision; constipation; nausea; vomiting; bloating; dizziness; urinary retention. All are anticholinergic effects and usually tolerable. Habituation and idiosyncratic reactions to phenobarbital (Cantil with Phenobarbital) are possible, as is generalized rash. DOSAGE: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required. HOW SUPPLIED: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

in moderate hypertension and
poorly controlled mild hypertension
(when diuretics or sedatives are inadequate, for example)



When your patients expect a lot...

like relief from hypertensive symptoms
(headache, fatigue, nervousness, palpitation or insomnia, for example)

like an up-to-date, once-a-day dosage schedule
(a schedule not unlike timed-release medication, for example)

like a daily dose of medication for peanuts
(at 10¢ a tablet, for example)

like generally well-tolerated therapy
(as described in the package insert, for example)

...give them a little
(one tablet daily)

Regroton®

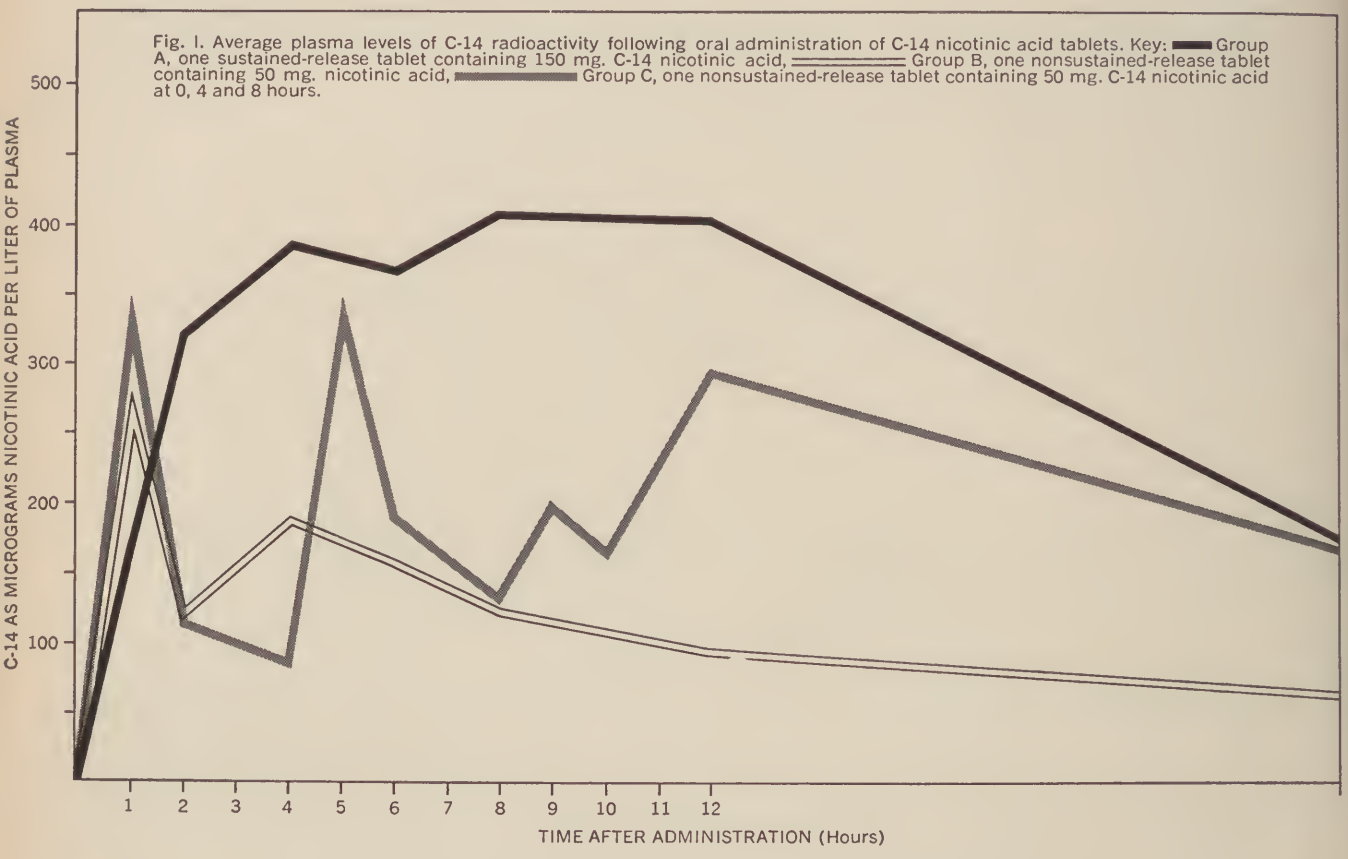
chlorthalidone 50 mg., reserpine 0.25 mg.

Indications: Hypertension. **Contraindications:** History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. **Warning:** With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Regroton should be used in pregnant patients or in women of childbearing potential only when, in the judgment of a physician, its use is deemed essential to the welfare of the patients; adverse reactions (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.
Precautions: Antihypertensive therapy with Regroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue Regroton therapy two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Regroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. **Average Dosage:** One tablet daily with breakfast. **Availability:** Pink, single-scored tablets in bottles of 100 and 1000. (B) 46-600-B
For details, see complete Prescribing Information.

Geigy Pharmaceuticals, Division of
Geigy Chemical Corporation, Ardsley, N.Y.

Geigy

Sustained circulatory, respiratory and cerebral stimulation for the





(fewer absent doses by absent-minded patients)

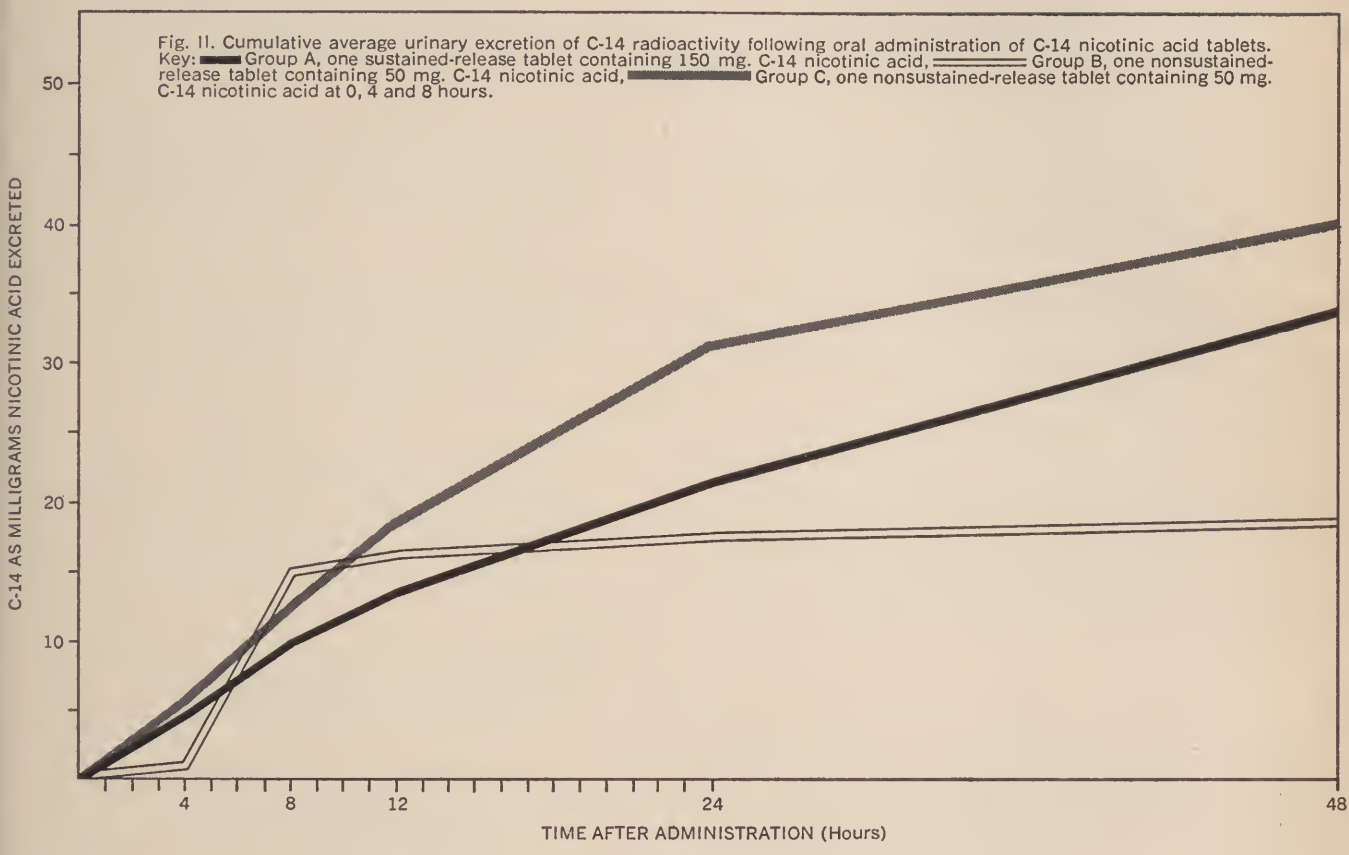
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

aged and debilitated



less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

"First with the Retro-Steroids"
PHILIPS ROXANE LABORATORIES
Division of Philips Roxane, Inc., Columbus, Ohio
A Subsidiary of Philips Electronics and Pharmaceutical Industries Corp.

Geroniazol® TT

nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol® Time Controlled Tablet

170th ANNUAL MEETING OF THE

APRIL 17, 18, 19
BALTIMORE

WEDNESDAY, APRIL 17

THE ALCAZAR

P.M.

2:15 *THE SURGICAL MANAGEMENT OF DISORDERS OF THE ADRENAL CORTEX*
J. HARTWELL HARRISON, MD
Peter Bent Brigham Hospital

3:15 *CIRRHOSIS OF THE LIVER: A PANORAMIC VIEW*
CHARLES M. CARAVATI, MD
Medical College of Virginia

4:15 *CINE CORONARY ARTERIOGRAPHY IN EVALUATING MEDICAL AND SURGICAL THERAPY FOR CORONARY ATHEROSCLEROSIS*
F. MASON SONES, JR., MD
Cleveland Clinic Foundation

QUIZ THE EXPERTS LUNCHEON
Wednesday, April 17
12:30 P.M.
Sheraton-Belvedere Hotel

An opportunity to discuss with the "experts" various medical subjects—make a selection from 23 different areas of medicine!

AMA-ERF THEATRE BENEFIT
Wednesday, April 17
8:30 P.M.
Morris Mechanic Theater

You Know I Can't Hear You When The Water's Running

starring Eddie Bracken

THURSDAY, APRIL 18

THE ALCAZAR

A.M.

9:30 *MEDICAL GRAND ROUNDS*
Presented by **A. McGEHEE HARVEY, MD** and **STAFF**
The Johns Hopkins University School of Medicine

11:00 *CHRONIC NEPHRITIS REVISITED*
MAURICE B. STRAUSS, MD
Tufts University School of Medicine

P.M.

2:00 *SURGICAL GRAND ROUNDS*
Presented by **ROBERT W. BUXTON, MD** and **STAFF**
University of Maryland School of Medicine

3:30 *MYOCARDIAL REVASCULARIZATION*
ARTHUR M. VINEBERG, MD
The Royal Victoria Hospital

ANNUAL PRESIDENTIAL RECEPTION AND DINNER
Thursday, April 18
6:15 P.M.
Sheraton-Belvedere Hotel

ART BUCHWALD, internationally known columnist, lecturer, author, television and recording star, will speak on *SON OF THE GREAT SOCIETY.*



Art Buchwald

A DETAILED PROGRAM WILL BE MAILED TO ALL MEMBERS

MEDICAL AND CHIRURGICAL FACULTY

APRIL 21-28, 1968
CARIBBEAN CRUISE CONVENTION

FRIDAY, APRIL 19

THE ALCAZAR

A.M.

9:30 *CARE OF THE UNSTABLE DIABETIC*
CLIFFORD F. GASTINEAU, MD
Mayo Clinic

10:30 *RECENT ADVANCES IN X-RAY DIAGNOSIS OF SURGICAL DISEASES*
STANLEY BAUM, MD
Graduate Hospital, University of Pennsylvania

11:30 *SAFETY OF ORAL CONTRACEPTIVES*
LOUIS M. HELLMAN, MD
State University of New York

HOUSE OF DELEGATES MEETINGS
Wednesday, April 17, 9:30 A.M.
The Alcazar
Friday, April 19, 2:00 P.M.
Faculty Building
All Faculty members welcome

HEALTH EVALUATION TESTS
Available to members of the Faculty and their guests
Wednesday, Thursday and Friday
April 17, 18, 19
The Alcazar, Baltimore

TECHNICAL AND SCIENTIFIC EXHIBITS
Wednesday, Thursday, Friday
April 17, 18, 19
The Alcazar, Baltimore
See page 135 for list of exhibitors

APRIL 21 - 28

SS ARGENTINA

A COMPARISON OF DIURETICS
RICHARD D. BAUER, MD

EXPERIENCES WITH AN ALCOHOLIC DETOXIFICATION UNIT IN A COMMUNITY HOSPITAL
ROLAND T. SMOOT, MD

OUR TURBULENT YOUTH
CAROLYN S. PINCOCK, MD

THE TEACHING COMMUNITY HOSPITAL: ETHICAL IMPLICATIONS
EMIDIO A. BIANCO, MD

MUSCLE DISEASE: A SURVEY FOR ALL PHYSICIANS
JOHN COLLINS HARVEY, MD

TEN YEARS' EXPERIENCE WITH HEMODIALYSIS
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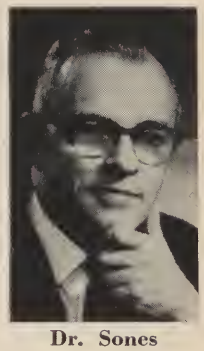
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More About the Speakers at the 170th Annual Meeting of the Medical and Chirurgical Faculty Wednesday, April 17 to Sunday, April 28, 1968

See previous issues of the JOURNAL for information about other speakers—See the ANNUAL MEETING PROGRAM, for complete information about speakers and various functions—Copy will be mailed to all members and to others upon request.



Dr. Sones

F. MASON SONES, MD, will speak on Wednesday, April 17, at the Alcazar in Baltimore. His subject will be **CINE CORONARY ARTERIOGRAPHY IN EVALUATING MEDICAL AND SURGICAL THERAPY FOR CORONARY ATHEROSCLEROSIS.** Dr. Sones received his AB from Western Maryland College in Westminster, Maryland, and his MD from the University of Maryland School of Medicine. He served an internship at the University of Maryland Hospital and a residency in internal medicine and cardiovascular disease at The Henry Ford Hospital. From 1950 until 1966, he was Director of the Cardiac Laboratory and Pediatric Cardiology at the Cleveland Clinic Foundation, and in 1966 was appointed Director of Department of Cardiovascular Disease and the Cardiac Laboratory, Cleveland Clinic Foundation. Since 1955, Dr. Sones's primary interest has been in the development of techniques combining cardiac catheterization with high speed X-ray motion picture techniques for clinical application to the diagnosis of lesions in the central circulation. Dr. Sones is a Fellow of the American College of Chest Physicians, American College of Cardiology, Council on Clinical Cardiology and Council on Epidemiology of the American Heart Association. Among the many awards conferred on Dr. Sones are: The Golden Eagle Award for Cinematography; the American College of Chest Physicians Film Award; Distinguished Achievement Award, Modern Medicine; Theodore and Susan Cummings Humaritarian Award; Duff Memorial Lecturer, Council on Atherosclerosis, American Heart Association; Jackson Memorial Lecturer, New England Cardiovascular Society; Rigler Memorial Lecture, University of Minnesota; and the Haile Selassie Lecturer, Royal College of Physicians, London.



Dr. Baum

STANLEY BAUM, MD, Associate Professor of Radiology, University of Pennsylvania School of Medicine, will give a paper on **RECENT ADVANCES IN X-RAY DIAGNOSIS OF SURGICAL DISEASES** on Friday, April 19, at the Alcazar, Baltimore. After receiving his BA at the University College of Arts and Science of New York University, Dr. Baum received his MD at the Faculty of Medicine, University of Utrecht, Holland. He did postgraduate work at the Graduate School of Medicine of the University of Pennsylvania and in 1961 received a Certificate of Satisfactory Completion and Eligibility for Advanced Degree. Dr. Baum served an internship at the Kings County Hospital Medical Center and a radiology residency at the Graduate Hospital of the University of Pennsylvania. These were followed by a traineeship of the National Cancer Institute, and a fellowship in cardiovascular radiology at Stanford University Medical Center. He was board certified by the American College of Radiology in 1963. Dr. Baum has participated in the development of scientific exhibits which have been displayed, and received awards, at national, regional, and state medical meetings. He is the author or co-author of numerous published articles and chapters of medical books. Dr. Baum is Assistant Radiologist at the Graduate Hospital of the University of Pennsylvania, and Consultant in Cardiovascular Radiology at the Veterans Administration Hospitals both in Philadelphia and Wilmington, Delaware.

THE MONTH IN WASHINGTON

Dwight L. Wilbur, MD, president-elect of the American Medical Association, warned that physicians will resist any effort to establish national medical standards under the Regional Medical Programs.

But he predicted that the medical profession would cooperate enthusiastically if the programs are carried out on a voluntary cooperative basis.

Dr. Wilbur spoke at a conference on Regional Medical Programs sponsored by the Department of Health, Education and Welfare.

"If the program in fact is clearly one designed to catalyze and to facilitate the development of better programs than now exist to serve patients and their physicians, it will undoubtedly receive enthusiastic cooperation from the medical profession and related groups," Dr. Wilbur said. "We know that the law and its legislative history stress the voluntary cooperative nature of the program and that interference with existing patterns is specifically prohibited. . . .

"Unlike many other countries, our nation has reached its preeminence in many areas of activity because of this unique combination of multiple independent focal points of activity cooperating on a voluntary basis to achieve a commonly desired goal. . . .

"If RMP maintains its current emphasis on the working together of regional groups, it will fulfill its purpose of improving the quality, accessibility and availability of health care, physician and institutional performance, and consumer satisfaction.

"On the other hand, if RMP becomes an instrument for the establishment of national standards with the coercive compliance compelled by such standards, it will arouse nationwide resistance from physicians, institutions, and allied health professionals. What can be gained by cooperation and meaningful participation will surely be lost if the use of coercive power, which for the moment lies dormant in Public Law 89-239, becomes its dominant characteristic. . . .

"RMP is in a strategic position to bring about changes acceptable both to physicians and their patients that will improve performance and patient satisfaction without undermining patterns of behavior that are traditional, and, more significant, considered by the medical profession essential to the preservation of high quality care."

* * *

The American Medical Association told Congress that weight reduction is a leading health area for quackery.

The AMA position on weight reduction, particularly as so-called diet pills are involved, was outlined by Theodore B. Van Itallie, MD, of New York, N.Y., a member of the Council on Foods and Nutrition, and Harry C. Shirkey, MD, of Birmingham, Ala., vice chairman of the Council on Drugs, in testimony before the Senate Antitrust and Monopoly Subcommittee.

The subcommittee was investigating reports that some osteopaths and physicians were making large incomes from assembly-line administration of multi-colored "diet" pills containing such drugs as barbiturates, thyroid extract, amphetamines, thiazine, diuretics, laxatives and various hormones.

Officials of Illinois and Oregon testified that such pills were involved in at least 20 deaths in their states.

"Perhaps in no other area of health and medical problems do we encounter as much food faddism and quackery," Dr. Van Itallie testified. "The obese are extremely gullible, forever willing to believe that someday a gadget, a diet, a pill, or a book will lead to the miracle of easy and painless reduction of weight. While most of the quackery originates with health hucksters who have no scientific background, training, or qualifications in the medical or nutritional fields, unfortunately a physician is occasionally involved.

"The American Medical Association has long utilized its various publications to bring to the profession and the public up-to-date information on the latest scientific advances in the area of

obesity control. It frequently focuses attention upon those irregular practitioners and faddists who prey upon the unsuspecting public. As the national voice of Medicine, we believe that it is incumbent upon us to help protect the public from those practices which have the potential of adversely affecting the public health. . . .

"A physician who assumes the responsibility for treating obesity takes on a difficult role. Few other medical disorders require the same disciplined and prolonged cooperation of the patient in their treatment. Even under the best of circumstances, the results of treatment become apparent slowly. The inherent handicaps may strain the busy physician's patience and tempt him to resort to unsound methods of treatment. He must have a clear understanding of the physiological and psychological problems of obesity in order to treat it wisely."

Dr. Shirkey broke down weight drugs into seven general classifications: (1) cardiac glycosides; (2) hormones, chiefly thyroid; (3) diuretics; (4) anorexiants (appetite suppressants); (5) laxatives; (6) sedatives; and (7) antispasmodics. Of them he said:

Cardiac glycosides: "Their use for obesity is reprehensible and may well have attributed to the few reported deaths of patients receiving such treatment."

Hormones—Thyroid: "There are at least three irrationalities . . . in this hormonal approach to the treatment of obesity."

Diuretics: "There is no rational basis for the use of diuretic drugs in the treatment of simple obesity."

Anorexiants: "Amphetamines are useful as a crutch to help the patient become accustomed to a rigorous reducing diet. But long-term administration is not justified because they tend to become less effective and, in addition, can lead ultimately to habituation."

Laxatives: "There is little rational basis for the use of laxatives in the treatment of obesity."

* * *

President Johnson said the administration would take additional steps to abate the increases in health care costs and to increase the numbers of health personnel.

In his economic message to Congress, he said, "The supply of qualified health personnel has lagged behind the expanding demand. I will shortly propose new measures to increase this supply.

"Last year, medical care prices rose 7%, more than twice as fast as other prices. I shall propose new measures to slow down the spiraling cost of health care."

In his State of the Union message, the President included in a list of "absolutely intolerable" conditions which he said had existed for many years: "Hospital and medical costs are high, and they are rising." He did not amplify the brief statements in either of these two messages, leaving the details for a later health message to Congress.

Chairman Abraham A. Ribicoff (D., Conn.) said the Senate Government Operations Committee would conduct a two-year investigation into the rise in hospital and other health care costs. He said the subcommittee's study also would be concerned with the numbers of physicians and other health personnel.

Mr. Johnson said he also would propose a child health program and stricter penalties for those who traffic in LSD and other dangerous drugs. The child health program would provide poor families over the next five years with health service from prenatal care of the mother through the child's first year.

The budget for the Department of Health, Education and Welfare allotted $66 million for medical education in fiscal 1969, for the year beginning next July 1, an increase of more than $16 million. Federal aid for allied health training was increased from $19 million to $19.2 million.

Medicare expenditures for fiscal 1969 were estimated at $6.3 billion, compared with $5.7 billion for the current fiscal year.

Family planning programs of the federal government would be greatly expanded. The goal is to provide birth control information to one million women by quadrupling the size of the family planning services budget from $6 million to $24 million.

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March 17-23

To keep us reminded of the seriousness of accidental poisonings, the National Planning Council is observing its 7th annual National Poison Prevention Week, March 17-23.

This year an estimated 500,000 children will be victims of accidental poisonings. Ninety percent of all cases reported involve children under 5 years of age.

As one of the 21 agencies comprising the National Planning Council, the AMA strongly urges all state and local medical societies to help reduce the incidence of poisonings in the community by alerting all citizens to the proper use and storage of potentially haardous substances. To assist the medical societies in implementing local poison prevention campaigns, a packet of materials is available, free of charge. Write Henry L. Verhulst, Secretary, National Planning Council, US Public Health Service, 7915 Eastern Ave., Silver Spring, Md. 20910.

In addition, the AMA has several pamphlets on poison prevention. "Danger Lurks," "Medicines and How to Use Them," and "Protecting Your Home from Unlabeled Poisons" are available from the AMA Order Handling Department for 10 cents each. The "First Aid Manual" is 15 cents each or $12 per hundred.

Remember—National Poison Prevention Week makes every week poison prevention week.

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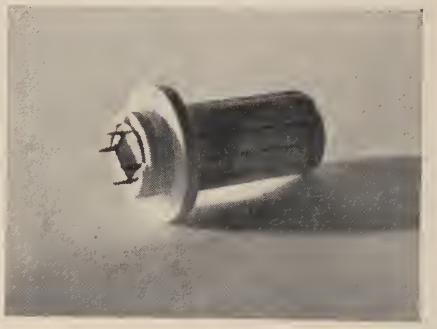
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FRIDAY PROGRAMS

APRIL 5—12:30 P.M.

Diagnosis and Therapy of Gout

L. Myrton Gaines, Jr., MD, Instructor of Medicine, The Johns Hopkins University School of Medicine

Sponsor: The Arthritis and Rheumatism Foundation of Maryland

APRIL 12—12:30 P.M.

Chronic Intermittent Hemodialysis in a Community Hospital

William G. Esmond, MD, Associate in Medicine, Assistant Professor in Surgery, University of Maryland School of Medicine

Sponsor: St. Joseph Hospital

APRIL 19

No Medic Lecture

170th Annual Meeting
Medical and Chirurgical Faculty of the State of Maryland
Baltimore

APRIL 26—1:00 P.M.

Catecholamines

Karl Engleman, MD, Senior Investigator, Experimental Therapeutics, Branch, National Heart Institute, National Institutes of Health

Sponsor: Frederick Memorial Hospital

CONTINUING PROGRAMS

(Heard at participating hospitals only)

TUESDAY MORNINGS—11:30 A.M.

MEDICAL GRAND ROUNDS
University of Maryland Hospital

FRIDAY AFTERNOON—2:00 P.M.

NEUROLOGY GRAND ROUNDS
University of Maryland Hospital

SATURDAY MORNINGS—8:00 A.M.

PEDIATRIC GRAND ROUNDS
The Johns Hopkins Hospital

SATURDAY MORNINGS—10:00 A.M.

MEDICAL GRAND ROUNDS
The Johns Hopkins Hospital

Participating hospitals:

Anne Arundel General, Annapolis
Baltimore City, Baltimore
Baltimore County General, Randallstown
Calvert County, Prince Frederick
Cambridge-Maryland, Cambridge
Carroll County General, Westminster
Church Home, Baltimore
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Easton Memorial, Easton
Eugene Leland Memorial, Riverdale
Frederick Memorial, Frederick
Greater Baltimore Medical Center, Towson
Harford Memorial, Havre de Grace
The Johns Hopkins, Baltimore
Kent General, Dover, Delaware
Kent & Queen Anne's, Chestertown
Keswick Home for Incurables, Baltimore
Lutheran, Baltimore
Maryland General, Baltimore
Montgomery General, Olney
North Charles General, Baltimore
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Prince George's General, Cheverly
Provident, Baltimore
Rosewood State Hospital, Owings Mills
Sacred Heart, Cumberland
St. Joseph, Baltimore
St. Mary's, Leonardtown
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Other locations:

Harford County Health Department, Bel Air
Medical and Chirurgical Faculty, Baltimore
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APPROPRIATE CREDIT WILL BE GIVEN BY THE AMERICAN ACADEMY OF GENERAL PRACTICE FOR ATTENDANCE

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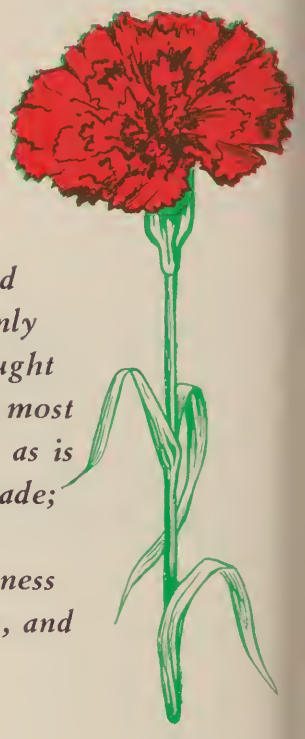
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Doctors' Day—March 30th



*There are men and classes of men that stand above the common herd: the soldier, the sailor and the shepherd not unfrequently; the artist rarely; rarelier still, the clergyman; the physician almost as a rule. He is the flower (such as it is) of our civilisation; and when that stage of man is done with, and only remembered to be marvelled at in history, he will be thought to have shared as little as any in the defects of the period, and most notably exhibited the virtues of the race. Generosity he has, such as is possible to those who practise an art, never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments; and what are more important, Heraclean cheerfulness and courage. So it is that he brings air and cheer into the sickroom, and often enough, though not so often as he wishes, brings healing.**

Doctors' Day is a special day observed each year to honor the members of the medical profession who have devoted their lives to the art of healing. March 30th, the official date, commemorates one of the greatest discoveries for the alleviation of pain and suffering for on this day in 1842, Dr. Crawford W. Long first used ether anesthesia in surgery. The red carnation was chosen in 1949 as the symbol of Doctors' Day.

In recognition of the doctors' contributions to the people and communities they serve, the Heart Association of Maryland will dedicate their window with a display in honor of Doctors' Day.

Also in honor of Doctors' Day, a contribution will be made by our auxiliary to the American Medical Association Education and Research Foundation, to be divided equally between The Johns Hopkins and The University of Maryland Schools of Medicine.

Mrs. Max R. English, President
Woman's Auxiliary to the Baltimore City Medical Society

Mrs. Raymond L. Markley, Chairman
Doctors' Day

**from* Underwoods *by Robert Louis Stevenson with permission of the Author's Literary Estate; and Chatto and Windus Ltd., London, England.*

Editorial
Maryland State Medical Journal
Vol. 17, No. 3
March, 1968

THE THREAT TO MEDICINE

The threat to our medical freedom is a lot more subtle than that which we face from our government. It comes from our brethren in the field of hospital administration. These gentlemen have gone far in their quest for power as evidenced by the attitude of a recent applicant for the post of hospital administrator. In referring to his previous hospital, he described the hospital as "his" hospital and the doctors as "his" doctors and the board of directors as "his" board of directors. To him, all of these people have a subservient function to his ultimate aims. These aims are to form medical centers in which the hospital administrator would direct all activities.

The hospital administrator, at one time, was a man of consequence and upon his shoulders fell the burden of the financial solvency of the hospital. Today, he has little to worry about, all he has to do is operate within the Blue Cross formula which is not always the most economical.

The responsibility for the high cost of hospitalization is directly attributable to these gentlemen; they have a tendency to create small empires and to be wasteful in manpower and materials. The abuses in the field of hospital administration are brought about by the fact that hospital administrators operate in an area which could be well described as a "no man's land" consisting of a board of directors, with the medical staff somewhere in the background.

Under the pretext of conflict of interest the administrator is able to keep these two boards far apart. Under the guise of conflict of interest there is very little communication between these two boards except through the hospital administrator, who is able to present his own views to the ruling body.

The cost of hospitalization has skyrocketed while the doctor's fee has remained relatively stationary. The unknowing public makes little or no distinction between the cost of hospitalization and the fees of practicing physicians. The resulting consequence is that the medical profession as a whole bears the brunt of the criticism while the hospital administrator goes blithely about his business.

I contend that to remedy this situation more doctors should participate in the decisions of the board of trustees as trustees. Instead, an ever increasing chasm between administrators and doctors is becoming more apparent as time passes. The current trend seems to be to relegate the doctor to anonymity, the status of the doctor dwindles and the status of the administrator takes on greater dimensions. Perhaps it is time for a self evaluation by the administrator. It would seem that the administrator has lost sight of the fact that it is the doctor and patient around whom the hospital revolves.

There is no question that the "concept" of total medical care for patients would be enhanced if there were more communication between the board of directors and the doctors. There is also no question that the operation of the hospital would be much more economical and efficient.

R. F. Archambault, MD
Wayne, Michigan

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The Author

The practice of medicine on the Antarctic continent is not unlike the practice of military medicine in less remote areas of the world. One is generally dealing with a young, healthy population which is exposed to environmental hardships, heavy work, and long hours. In this situation preventive medicine assumes paramount importance.

ROBERT M. BEAZLEY, MD
Former Officer in Charge and Medical Officer,
Amundsen Scott South Pole Station, Antarctica
Currently Resident in Surgery,
University of Maryland Hospital

MEDICAL OFFICER AT 90° SOUTH

Captain Hedblom, MC, USN, has likened the polar medical officer to a life guard "who seems to spend most of his time directing traffic, stopping dog fights, answering questions by the thousands, and sweeping out locker rooms. When occasion arises however, the guard must be able to quickly and efficiently rescue the drowning and expertly apply resuscitative measures should they be necessary. Practically, the life guard's most lasting contribution to society lies in his teaching of swimming, life saving, and water safety."[1]

From my experiences as Officer in Charge and Medical Officer at the Amundsen Scott South Pole Station I can enthusiastically appreciate Captain Hedblom's parallel.

The U.S. Navy's medical program in Antarctica is largely one of preventive medicine. This begins with the initial screening of volunteers. Strict physical and dental requirements, formulated from experience, are laid out in the Manual of the Medical Department, U.S. Navy, Section 15-31. The screening physical examination is frequently performed by a physician who is an Antarctic veteran. Obviously, recurrent back trouble, history of internal derangement of the knee, or any evidence of peripheral vascular disease would be disqualifying.

Minor findings on a State-side physical can become major problems in the remoteness of Antarctica. For instance, the "few skin tags" noted on my radioman's initial physical examination became prolapsed gangrenous hemorrhoids several weeks after arrival at the South Pole. This resulted in a three-thousand mile air evacuation for treatment and the loss of four weeks of vital manpower. The initial physical examination, probably one of the most stringent in the Navy, generally turns away 10 to 20% of the "healthy" volunteers. This examination is followed by intensive psychological testing and psychiatric interviewing which turns away another 10 to

The opinions and assertions expressed herein are those of the author, and are not to be construed as reflecting the views of the Navy Department or of the naval service at large.

20% of the volunteers. The selected "Winter-Over Volunteer" is general twenty-five to twenty-seven years of age, married, a petty officer with approximately eight years of Naval service, and of exceptional technical ability. Further informal screening is done by his superiors during the eight- to ten-month training period before deployment to the "Ice" in September of each year. The validity of these screening procedures, particularly the psychiatric screening, is attested to by the negligible number of volunteers who have left the "Ice" before completion of their tour of duty.

I found the station's outside environment to be less of a health hazard than I had anticipated. We were able to work outside for prolonged periods during the summer (October through February). At temperatures of minus 18° Fahrenheit, clothing worn in the middle Atlantic states at temperatures twenty to thirty degrees warmer was sufficient.

The absence of humidity on the Polar plateau, the continual sunlight of the Austral summer, and the near absence of ground winds made the work day relatively pleasant. However, the absence of humidity was dramatically offset during the winter by the twenty-four hour darkness (March through September) and the seemingly constant ground winds of ten to twenty knots. During this period, the monthly average temperature might be in the minus 80's. Necessity dictated that daily outside duties be accomplished at these temperatures. Outdoor work periods of sixty to ninety minuthes were tolerated by most men with only mild discomfort. In fact, the entire station's crew worked outside shoveling snow into the snowmelter on 25 July 1965, when we experienced a record low of minus 113° degrees Fahrenheit. Everyone quickly learned that care must be taken while outdoors to avoid "frost nip" or first degree frostbite. Frostnip, the equivalent of a moderate sun burn, can occur in forty-five seconds when finger tips, nose, ears, or malar prominences are exposed to wind at these extreme temperatures. Although I encountered almost daily cases of insignificant "frost nip," fortunately there were only three cases of second degree frostbite. Two of the cases involved the hands and the third involved the plantar surfaces of both heels. All recovered with the rapid rewarming technique and conservative therapy.

The Austral summer is met with unbelievable activity by the Navy and the United States Antarctic Research Program's scientific people. The Navy is charged with the support of the scientific efforts. At the Amundsen Scott South Pole Station (1964-65) there were seven civilian scientists working in five disciplines ranging from seismology to ionospheric physics. These men were backed up by 14 Navy volunteers. Most of the summer was spent in new construction and



Main Entrance Tunnel, South Pole Station—Black dome to the left is Rawin dome house tracking antennae for weather balloons. Surface building to the right is the aurora observation building used during the winter season in observing and recording the "Aurora Australis."



Blowing snow obscures the sun and surface topography at the South Pole Station.

repair of existing facilities, as well as resupply. During the summer nearly 120 ski-equipped C-130 aircraft landed at the station off loading in excess of two-million pounds of fuel and cargo. The hazards of any type of heavy cargo operation are obvious. However, these were compounded by the low temperatures which precluded shutting down the aircraft's turboprop engines. In addition to prop blast, high noise level, and frequent poor visibility, the station's altitude of 9,200 feet made man-handling 55-gallon fuel drums and JATO bottles pure torture. The average barometric pressure was twenty and eight hundredths inches of mercury[2] which is equivalent to an evaluation of about ten thousand feet. At this level the oxygen concentration of air is reduced to 14% or about two thirds that at sea level. Concomitantly, hemoglobin saturation is 90%. Initially, most men felt the effects of altitude sickness namely, dizziness, headache, and occasional nausea. However, after two to three days the obvious effects wore off and the men were able to perform their duties at a reduced pace. Within 30 days most men demonstrated elevation of blood values with hematocrits in the high fifties and a few in the low sixties. It was noted that the cold thin air would produce a mild tracheobronchitis if one exerted himself to the point of deep gasping type respirations. This was marked by moderate to severe retro-sternal burning seinsations, occasional blood-tinged sputa, and a chronic, non-productive cough. All personnel soon learned to cope with these rugged outside conditions and no lasting effects were experienced.

The internal environment of the station consisted of ten prefabricated buildings which over the past decade had been drifted in by the relentless blowing snow. Summer work and repair effects had succeeded in developing a system of covered passageways between adjacent buildings. Today, the resulting complex is buried by eight to ten feet of drifted snow. Living in such close quarters we were fortunate to be relatively free of respiratory infections. Once the last plane had departed in late February 1965, we were totally isolated from the outside world and managed to spend the winter . . . "cold" free. However, we were not without many of the other problems of crowded living. There was the ever present danger of fire from the oil-fired, hot air heaters found in each building, or from faulty or makeshift electrical wiring. The fire problem was compounded by the fact that we were living in a desert as far as water for fire fighting was concerned. For this reason, all personnel were given an intensive two-week course in dry chemical structural fire fighting prior to deployment. Carbon monoxide monitors in each building guarded us against the possibility of a report of Admiral Richard Byrd's 1934 *Alone* experience.[3] Other gases used on the station daily were equally as dangerous as carbon monoxide. Ammonia gas

used in the production of hydrogen for the weather balloons can be lethal. Its noxious fumes drove us from the station on Easter Sunday 1965 when the valve on a tank of liquid ammonia cracked due to low temperatures. In the summer of 1966, the recently constructed, specially designed balloon inflation shelter was leveled by a presumable hydrogen leak explosion during inflation operations. Miraculously, there were no casualities in either of these mishaps. Along this same line, the very dry air, the extreme amount of static electricity, and the practical impossibility of proper grounding precluded the use of most inhalation anesthetics. At Pole Station only local or regional anesthesia was available. Furthermore, the difficulties with grounding, compounded by the very dry air and high altitude which increased the frequency of component failures, made the work of the station's electronic personnel potentially lethal.

My Antarctic experiences pointed up to me vividly the preventive medicine attributes of good nutrition. A minimum of thirty-five hundred calories daily were supplied for each man. In addition, there seemed to be an excess of luxury items . . . steak, lobster, and king crab. These dietary treats did a great deal to maintain morale during the "long winter night." I feel certain that the accomplishments and general welfare of any small inland Antarctic station will be directly proportional to the cook's culinary abilities and his psychophysiological adjustment. In my opinion, he is the key man during an extended isolation situation of this type.

Fortunately, while I was the "life guard" there were no "saves" to be made. Perhaps we were lucky as the groups before us had been, but I doubt it. More likely the luck was the result of good preventive medicine and safety engineering.

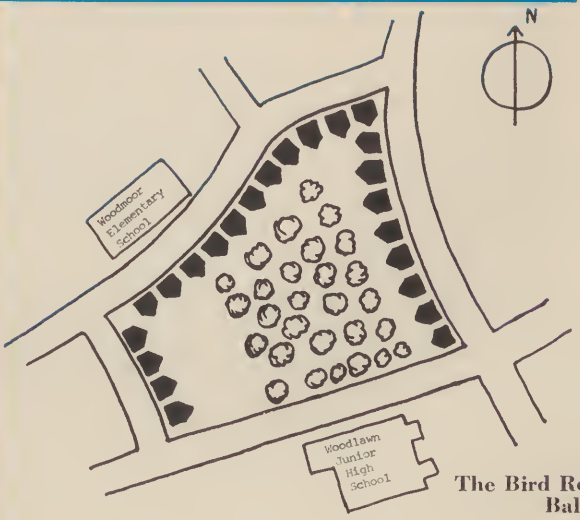
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—Official Navy Photographs

Summer Work Crews—Working at temperatures of −20° F, repair camp building damaged by the winter's drift snow.



The Bird Roost In The Woodmoor Section Of Baltimore County, Maryland

The histoplasmin skin test survey reported below in the result of interest generated by a bird roost in Baltimore County discovered during the fall of 1965. Dr. Scalia discusses the epidemiological study of this roost and the results of the survey.

A HISTOPLASMIN SKIN TEST SURVEY IN BALTIMORE COUNTY, MARYLAND

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In the early fall of 1965, the Baltimore County Department of Health received many complaints relative to a bird roost in Woodmoor, a suburban neighborhood in the northwest section of Baltimore County. Several health department sanitarians inspected the bird roost and reported as follows:

The bird roost was part of a tract of land measuring approximately 5.8 acres. The northern 2.5 acres were dense with trees and underbrush and the birds roosted here. The flock of birds, estimated at 500,000, consisted of starlings, grackles and black birds. Bird droppings covered the ground and many tree branches to a depth of several inches. The birds had been roosting from late spring to fall for several years. There had been a marked increase in the number of birds in the summer of 1965, and this resulted in the complaints. The roost was surrounded on two adjacent sides by small private homes. At one end of the bird roost, across the street, there was the Woodlawn Junior High School. At the other end of the roost, there was the Woodmoor Elementary School. It was common knowledge in the neighborhood that school children often played in these woods or cut through them in going to and from each school. To compound the problem, the entire acreage had recently been sold for development and the developer was most anxious to clear the area completely and start his construction.

The sanitarians, while collecting soil samples, noticed that the air was filled with dust from the thousands of birds stirring about. Four soil samples pooled and studied at the Bureau of Laboratories of the Maryland State Department of Health cultured out Histoplasma capsulatum. A building permit was denied the developer and the area was posted with "No Trespassing" signs by the Department of Health.

Methods and Materials

In November, 1964, there had appeared an article in the *Antibiotic News* discussing the use of 3% formaldehyde for flushing a field infected with H. capsulatum.[1] A large bird roost in Mason City, Iowa had been associated with several fatal cases of histoplasmosis. The National Communicable Disease Center had conducted an extensive epidemiologic study and had followed up with the formaldehyde flushing. The Communicable Disease Center was contacted and Fred E. Tosh, MD, came to Baltimore to review the Woodmoor problem.

Forty-four surface soil samples were systematically collected from the area of the bird roost. In addition, a surface sample and depth samples at six and twelve inches were collected at three sites where the bird excreta was most heavily concentrated. It was decided to defer decontamination of the soil until the soil studies were completed. However, plans were made for a histoplasmin skin test survey to determine if the roost had been responsible for any infection among the school children in the two schools near the roost. For comparison studies, two similar schools at a distance away from the roost would also be involved in the histoplasmin program. With the advent of winter, it was agreed the bird roost hazard would be diminished so the histoplasmin project was planned for the spring of 1966.

In February, 1966, the 53 soil samples collected by Dr. Tosh were reported as negative on culture. The sub-culture of H. capsulatum from the Maryland State Laboratories was confirmed at the National Communicable Disease Center. The decision then was to continue with the histoplasmin skin test program in spite of the predominantly negative soils.

On March 9, 1966, Dr. Tosh and Robert Heusinkveld, MD, an associate from the Communicable Disease Center, in cooperation with the Baltimore County Department of Health, started histoplasmin skin testing.* Skin testing was performed on a voluntary basis with parental permission. The parents also had completed a questionnaire relative to the child's residences and possible relationships to farm life. The two schools selected for comparison were the Timonium Elementary School and the Ridgely Junior High School, located about ten miles northeast of the bird roost. The Board of Education of Baltimore County felt that these two schools were of similar socio-economic levels and best suited for comparison. The electric model jet gun was used for the actual testing and 2,695 children were tested at the four schools.



Geographic Location Of The Four Schools And The Bird Roost In Baltimore County, Maryland

Results

Of the 2,695 children tested, 72 had positive reactions for an overall reactivity rate of 2.7%. This is considerably lower than had been expected. Based on skin test surveys conducted elsewhere in the state of Maryland,[2,3,4] the reactivity rate was expected to be in the range of 25% to 40%. An attempt was made, therefore, to relate length of residence in Baltimore County to reactivity rate. Lifetime residents were defined as those having lived 80% or more of their lifetime in Baltimore County. By far, most of the children were lifetime residents, and this did not affect the reactivity rate, Table I.

Table II shows the results of the skin-testing program and compares the results of lifetime to non-lifetime residents at each of the four schools.

* The histoplasmin used was a 1:500 dilution of Lot HKC-5, prepared and standardized by the Kansas City Field Station of the National Communicable Disease Center.

TABLE I

Histoplasmin Sensitivity Among Children from Selected Schools in Baltimore County, Maryland

Length of Residence	Total Tested	Positive Reactors	
		Number	Percent
Lifetime	2114	52	2.5
Non-Lifetime	537	17	3.2
Unknown*	44	3	6.8
Total	2695	72	2.7

*Group of children who did not respond as to length of residence in Baltimore County.

TABLE II

Histoplasmin Sensitivity Among Children by School in Baltimore County, Maryland

School	Total Tested		Positive Reactors			
	Lifetime	Non-Lifetime	Lifetime		Non-Lifetime	
			Number	Percent	Number	Percent
Woodmoor Elem. Sch.	584	56	4	0.7	0	0
Woodlawn Jr. High	693	118	12	1.7	3	2.5
Timonium Elem. Sch.	358	143	7	2.0	4	2.8
Ridgely Jr. High	478	220	29	6.1	10	4.5
Unknown*	1	0	0	0	0	0
Total	2114	537	52	2.5	17	3.2

*One lifetime resident failed to indicate on the record the school attended.

It is immediately seen that histoplasmin sensitivity was lower among the students living near the bird roost than among those living ten miles away from the roost. As in studies elsewhere,[5] with an increase in age, there is an increase in reactivity rate, as seen by the higher rates among the older students in both junior high schools.

In Table III is summarized a history of residence on a farm in lifetime residents. Children having lived on a farm for a period of two or more years did, in fact, have a large percentage of positive reactors, but these were not enough to raise the overall reactivity rate. It is apparent that the population tested was mainly an urban one.

TABLE III

Histoplasmin Sensitivity by School and History of Residence on Farms* (Lifetime Residents Only)

School	Lived on Farm at Least 2 Yrs.			Never Lived on Farm		
	Tested	Positive Reactors		Tested	Positive Reactors	
		Number	Percent		Number	Percent
Woodmoor Elem. Sch.	1	0	0	571	4	0.7
Woodlawn Jr. High	7	0	0	668	12	1.8
Timonium Elem. Sch.	8	0	0	343	7	2.0
Ridgely Jr. High	50	4	8.0	407	24	5.9
Total	66	4	6.1	1989	47	2.4

*Does not include 59 children on whom such information was not available on records.

TABLE IV

Histoplasmin Sensitivity by Race and Sex* (Lifetime Residents Only)

	White			Non-White		
	Tested	Positive	Percent Positive	Tested	Positive	Percent Positive
Male	1060	24	2.3	11	2	18.2
Female	1025	25	2.4	9	1	11.1
Total	2085	49	2.3	20	3	15.0

*Does not include 9 children who did not report their race or sex on records.

Table IV summarizes histoplasmin sensitivity by race and sex among lifetime residents. It is interesting to note that sensitivity was much higher among non-white children than among white children. In view of Palmer and Edwards' studies[6] this was surprising, but the number of non-white children tested was small, so that this may not be a true reflection of histoplasmin prevalence.

Discussion

Emmons and Campbell[2] have shown that the isolation of H. capsulatum from the soil is perhaps the most conclusive evidence that infection in man and animals can be expected in a given area. The present study was initially undertaken because of such a finding. When the multiple soil samples collected by the Communicable Disease Center group proved negative for the fungus, it was decided to proceed with the skin-testing program to measure infectivity at the schools adjacent to the bird roost, and because such testing had never been performed on a large scale in Baltimore County. The finding of a very low reactivity rate proved that the bird roost was not a menace. The positive culture grown in the Bureau of Laboratories of the Maryland State Department of Health must have been a fortuitous finding.

Ajello[7] has implicated a variety of birds as being involved in histoplasmosis. However, he has shown that not all bird roosts are infected with the fungus, and conversely, he has isolated the fungus from areas without any apparent association with birds. He conjectures a relationship of the fungus to soil types, climate and biochemical activities of the micro-organism. The organism is not diffusely distributed in soils even in those regions classified as endemic. Campbell[8] reports low reactivity rates in regions of high endemicity, as in Kansas and Ohio, and high histoplasmin prevalence in certain areas of Maryland and Virginia, two states of low endemicity. Bats have also recently been implicated in histoplasmosis,[7,8] and bats are known to have a predilection for sites habited by birds. However, no bats were seen at the bird roost under study.

The presence of the fungus in the soil does not per se constitute a menace until the soil is disturbed and the spores are disseminated into the air. This has been seen in many epidemics, [9–14] in each of which the soil was disturbed by some undue activity such as farming, construction, clearing of underbrush or play activities of children. The bird roosts in most of these epidemics were long established and there had been heavy contamination of the soil. It is known that birds are not susceptible to histoplasmosis,[12] but that their excreta chemically fertilize the soil to activate the organisms. Probably very large accumulations of droppings over a prolonged period of time are required before this comes about. Residents could only guess that the bird roost under discussion had existed "for years."

Furcolow has presented many aspects of "urban histoplasmosis."[10,15,16] As cities spread further into suburban areas, this may become more of a problem. Since there is no means of protecting the individual by some sort of vaccination, public health control must depend on finding the organism and eradicating it from the focus. "Sanitizing the soil" infected with Histoplasma capsulatum has been difficult and expensive.[17] The chemical decontamination devised by Tosh and his group[18,19] sounds fairly easy and inexpensive, and studies to date seem to show it to be highly effective.

On the basis of the low histoplasmin reactivity rate and the sparse findings of H. capsulatum by the Maryland State Laboratory, decontamination of the site of the bird roost was not recommended to the developers. However, they were advised that during construction the area should be kept wet with water to prevent formation of dust and, thus, minimize airborne dissemination of spores. As a precautionary measure, they were also advised that laborers involved in the clearing and

excavating of the site should be histoplasmin positive. It was further recommended that if construction was delayed for a year or more, it would be wise to sample the soil again to make sure the fungus had not multiplied and become a true menace.

The owners of the acreage involved apparently have been reluctant to proceed with development and, as of this writing, the bird roost still stands. In 1966, no complaints were received by the Baltimore County Department of Health. In the spring of 1967, however, complaints came in. In cooperation with the United States Department of Interior, Bureau of Wildlife and Fisheries, the Division of Veterinary Medicine of the Maryland State Department of Health conducted a harassment campaign against the birds. This involved the use of carbide exploders, firecrackers and similar noise-makers to frighten the birds away. Although this campaign was fairly successful, the ultimate weapon in eliminating the birds as a nuisance is the destruction of the bird roost itself.

Summary

- A bird roost in the Woodmoor section of Baltimore County was found to be a possible source of histoplasmosis after soil samples studied by the Maryland State Laboratories cultured out Histoplasma capsulatum.
- Because of the proximity of two schools to the bird roost and because the acreage containing the bird roost was to be developed, the National Communicable Disease Center was contacted regarding this problem.
- Multiple soil samples collected by the CDC group were negative for H. capsulatum on culture.
- A histoplasmin skin test survey was conducted at the two schools adjacent to the bird roost and the findings were compared to two other distant schools similarly tested.
- The overall reactivity rate was much lower than had been expected and, in fact, the prevalence was even lower at the schools adjacent to the bird roost than at the more distant schools.
- The reactivity rate did not seem to be influenced by length of residence in Baltimore County.
- The population tested was mainly an urban one, so that residence on a farm did not enter as a factor.
- Based on the histoplasmin survey and the laboratory findings of the CDC group, it was concluded that the bird roost in question was not a menace and that the positive cultures found by the Maryland Laboratory were an accidental finding.
- The problem of Furcolow's "urban histoplasmosis" and decontamination of infected soil is discussed. Flushing the soil with 3% formaldehyde may be the answer to the problem.
- The histoplasmin skin test survey presented is the first ever to be conducted in Baltimore County.

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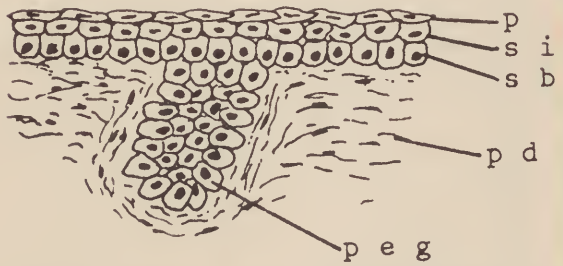
ALOPECIAS—DIAGNOSTIC AND PATHOGENETIC CONSIDERATIONS

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Few problems concerning the skin and its appendages are of so much concern to patients and physicians as alopecia. Hair loss is of interest because, as far as we know, hair is essentially without function. It is of concern because hair is exceedingly important from a cosmetic and psychological standpoint. The fact that aesthetic considerations of alopecia prevail is clear in that people have traditionally sought the advice of hairdressers and barbers for problems of hair loss. Many people seem to consider the hair peculiarly unrelated to the rest of their anatomy and hence quite outside the realm of medicine. However, as people are becoming more medically sophisticated this pattern is changing, and medical advice is sought more freely.

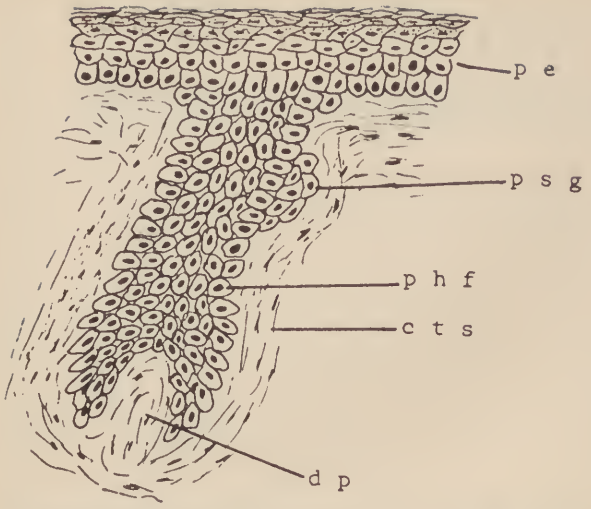
Anatomy and Physiology

The surface of the human fetus, up to one month of age, is covered by a one-cell thick ectodermal layer, the fetal periderm. At this time also, mesenchymal cells are proliferating beneath to form the dermis, which is finally to become the main bulk of the skin. During the second fetal month a second, inner, layer, the stratum basale, is added to the periderm. During the third fetal month a third layer develops so that from the outside in, there are periderm, stratum intermedium, and stratum basale. From the stratum basale small buds of cells known as primary epithelial germs proliferate down at intervals into the dermis. These buds are the anlagen of apocrine sweat glands, sebaceous glands, and hair follicles. The greatest population of these is on the head, where their development begins. Subsequent development proceeds caudally during the fourth and fifth fetal months. As the presumptive hair follicles enlarge and differentiate, their free advancing ends become clavate and each encloses a little ball of dermis, the dermal papilla. This tiny structure will later house the main blood supply to the hair-producing cells (matrix) of the follicle.



Primitive epidermis of a 12-week embryo, p—periderm, si—stratum intermedium, sb—stratum basale, pd—primitive dermis, peg—primary epithelial germ.

The presumptive follicle is now enlarged to a column of pluripotential epidermal cells. It progressively hollows out through the center to make way for the subsequent hair which will arise from a bulb of cells (matrix) surrounding the dermal papilla at the base of the follicle. At this time it is apparent that the major portion of the follicular wall, the external root sheath, is simply an extension of the now completely formed surface epidermis. At the fundus of this sac-like structure is a matrix of cells that produce hair, much like the surface epidermis produces stratum corneum. The main difference is that the latter desquamates and the former does not. There has been also a concomitant differentiation of part of the external root sheath into the sebaceous gland, so that this gland becomes an appendage in the wall of the hair follicle. In addition, further follicular blood sup-



Subsequent differentiation toward hair follicle and sebaceous gland, pe—primitive epidermis, psg—primitive sebaceous gland, phf—primitive hair follicle, cts—connective tissue sheath, dp—dermal papilla.

ply develops from surrounding dermal and subcutaneous vascular plexi.

The hair matrix has a high mitotic activity, comparable to that of the bone marrow. On the average adult scalp, which bears about 100,000 hairs, there is a daily production of 100 feet of hair. Hair, like the stratum corneum of the epidermis, consists mainly of keratin, a fibrous protein, and certain fats.

Fetal hair (lanugo hair) is present on the head by the fifth fetal month and subsequently appears over the remainder of the body. This hair, for the most part, is shed shortly before birth. (More on this phenomenon will be discussed later, as it relates to neonatal alopecia.) The newborn infant has a second pelage of lanugo-like (vellus) hair, of variable amounts. As he ages, he gradually acquires adult-type hairs. Morphologically adult hairs fall into six categories: (1) scalp, (2) eyebrow and eyelash, (3) beard, (4) body, (5) pubic, (6) axillary. Hormonally, adult hairs fall into three categories: (1) Non-hormonal (eyebrows and eyelashes, part of body hair), (2) hormone modified (scalp, axillary, lower pubic, part of body hair), (3) hormone dependent (upper pubic, beard).

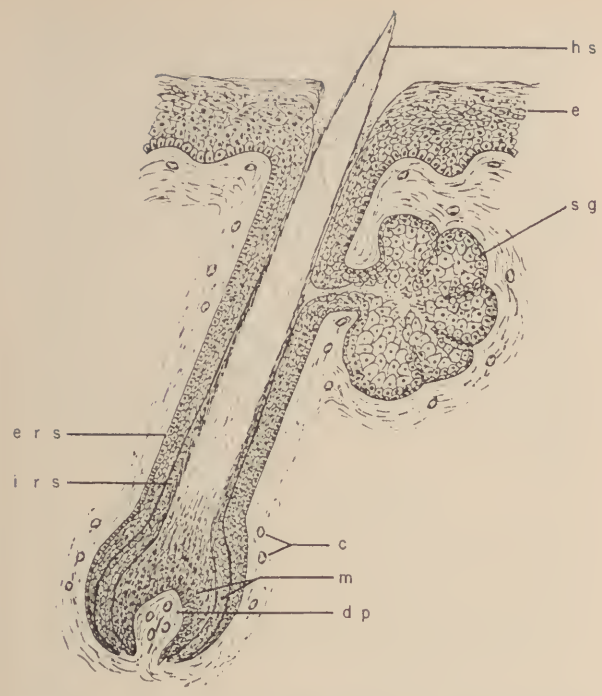
The growth of hair is characterized by cycles. This is true in most mammals. However, unlike the hair of other mammals, human hair grows in asynchronous cycles, ie., it does not molt. Each individual hair's cycle is independent of all others, so that growth patterns are random. The growing phase (anagen), in which there is continuous matrix proliferation and hair production, usually last two to six years in scalp hair, and for shorter periods in other hair. The regressing phase (catagen) lasts only about two weeks in scalp hair, and for about the same period in other hair. During this time the matrix involutes, the hair stops growing and the lower 2/3 of the follicle degenerates. The blood vessels in the dermal papilla and around the follicle collapse but do not degenerate. The resting phase (telogen) lasts two to six months in scalp hair and in other hair. At this time the hair is loosely implanted in the follicle. A new anagen phase begins as the few remaining matrix cells begin proliferating anew to start a new hair. The previously collapsed vessels reopen and re-establish the blood supply. The old telogen hair ("club hair") is pushed out, and the follicle grows back to its original length for the new anagen phase.

These phases can be easily recognized by the gross appearance of individual scalp hairs. If a firmly implanted (anagen) hair is plucked, a sticky grayish-white membrane is seen around the lower 2-3 mm, or the hair root. This membrane is actually the major portion of the follicle and matrix. However, enough cells of these two structures have remained behind to allow full regeneration of a new hair. If a loosely implanted hair (telogen or club) is plucked, a tiny, dry, bulb is seen at the lower end, covered by a few degenerated follicular cells. These club hairs are ordinarily thin, tapered, and light in color when compared to anagen hairs. The catagen phase is so brief that hairs therefrom are seldom seen, but their appearance lies somewhere between that of anagen and telogen hairs.

Normally in the young adult, 85 to 95% of scalp hairs are in the anagen phase, and 5 to 15% are in the catagen and telogen phases. With age, and in certain types of hair loss to be discussed later, these percentages change. The normal young adult ordinarily looses 20 to 100 club hairs daily, for an average loss of about 50 daily.

Neonatal Alopecia

A commonly observed phenomenon in infants is occipital hair loss followed by fronto-parietal hair loss. This sometimes causes parental anxiety and the mother may stop cleaning the baby's scalp for fear of making him bald. A satisfactory physiological explanation for this hair loss exists, and its temporary nature can be assured.



Mature hair follicle in anagen phase, with sebaceous gland. hs—hair shaft, e—epidermis, sg—sebaceous gland; sebum is the product of disintegration of these cells. c—capillaries, m—matrix; these cells produce not only hair shaft, but also internal root sheath (irs), which degenerates and desquamates within the follicle. dp—dermal papilla. ers—external root sheath, a continuation of surface epidermis (e).

In the fifth fetal month the majority of the frontal and parietal hair suddenly goes into catagen and then telogen phase. This is, in a sense, molting, which is different from the random hair cycles of the postnatal individual, as pointed out previously. This gross change to catagen and telogen moves posteriorly in a wave, so that in the eighth fetal month it has occurred in the occiptal hair. At this time a new anagen growth has appeared frontoparietally and has pushed the telogen hairs out into the amniotic fluid about three months after their change to telogen. At birth then, the new anagen growth is occurring frontally and parietally. Subsequently occipital hairs will be pushed out when the infant is in his second month of life, about three months after their change to telogen. The new anagen hairs are still very short and the infant looks bald in the occipital area. This telogen wave is often repeated, although less extensively, so that the infant again develops partial baldness progressing from the frontal to the occipital regions. The follicles then ordinarily re-establish their cycles in a random pattern, and normal postnatal anagen and telogen percentages are established over the scalp. By the age of eight to ten months these regional losses ordinarily no longer occur. The only treatment necessary is reassurance that the condition is temporary.

Telogen Effluvium

Temporary hair loss following periods of physiological stress likewise is a well known phenomenon. Most physicians have seen patients who, two to four months after childbirth, major surgery, or serious systemic illness, have either sudden or gradual loss of large amounts of hair. This is known as *telogen effluvium,* because it represents the sudden change of a large number of hair follicles from anagen to telogen. Older names for this phenomenon include symptomatic alopecia and defluvium capillorum. Kligman has written extensively on this subject, and the studies indicate that over 20% telogen hairs on the scalp is presumptively abnormal, and that over 25% telogen hairs is diagnostic of telogen effluvium.

Post partum telogen effluvium usually begins two to four months after delivery, and lasts two to five months, although it may last a year or more. If a small tuft of hair is plucked, it will be seen that telogen hairs constitute somewhere between 20% and 50%. It should be emphasized that this is true only if the loose telogen hairs have not been removed in part by recent vigorous brushing or shampooing. Ordinarily they remain in place until pushed out by a new anagen hair. This accounts for the fact that the patient is more likely to complain about the amount of hair that falls out than about the amount remaining on the scalp. Furthermore, thinning of scalp hair is seldom obvious if less than 50% is lost.

Studies during pregnancy have shown that in most women, starting in the second trimester, telogen percentage decreases, and anagen percentage increases reciprocally. At term the scalp hair may be 95% anagen. This is virtually a biologic characteristic of pregnancy but usually it goes unobserved. Shortly after delivery this trend reverses, and by six to nine weeks post partum the telogen count is up to 25 to 30%. At this time new anagen hairs begin pushing the relative excess of telogen hairs out, and patients may become aware of excessive hair loss. It should be understood that change in telogen percentage in the individual patient is more important than absolute values, since there is a wide range in the actual number of telogen hairs and in the rapidity with which they

change to telogen. Hence the actual degree of thinning present at any given time is quite variable, if, indeed, it is even detectable.

Post-febrile alopecia, formerly seen quite often following scarlet fever, lobar pneumonia, etc., is uncommon now, but studies have shown that the process is essentially like that described for post partum telogen effluvium.

Information on which to postulate the pathogenesis of post partum telogen effluvium has been sketchy and inconclusive. A retrospective study of 98 cases by Schiff and Kern gave information suggesting a hormonal basis. In their series two patients developed alopecia after caesarean sections. Most patients observed the greatest involvement on the anterior one-third of the scalp. Most of the remainder had diffuse alopecia. In nearly all cases, hair loss had occurred after all previous deliveries or miscarriages. In those cases where it had not, subsequent conception had occurred before the second menstrual period. Determinations of urinary 17-ketosteroid excretion on 11 of these patients revealed no abnormalities. Likewise, urinary 17-ketosteroids, 17-hydroxycortocosteroids, and gonadotropins on another series of nine patients were normal. Studies of urinary estrogen and progesterone are lacking. Perhaps the hyperestrogenemia of pregnancy and the sudden termination thereof at delivery is pathogenetic. Bullough points out that estrogens exert a powerful mitotic effect on epidermis as well as on the uterus and vagina. Moreover, it is known that adrenalin is a powerful mitotic depressant. Its effect on epidermal cells has been confirmed in mice. Since telogen effluvium apparently can occur after severe psychologic stress and since it is known to occur after such physiological stresses as childbirth, major surgery, and severe illnesses, it could also be reasoned that adrenalin precipitates the change to telogen. However, Bullough further states that while these hormonal effects occur in epidermis, they have not been demonstrated in hair.

If hormonal changes do influence telogen effluvium, they do not do so exclusively. Heparin, in addition to being an antimitotic agent, is known to induce telogen effluvium. Herein lies evidence at least that a depression of mitosis and a consequent premature change from anagen to telogen may be the common denominator. Furthermore, like the usual types of telogen effluvium, heparin-induced alopecia affects mainly the scalp. This is readily explained by the fact that scalp hair normally has a higher anagen percentage than other hair and is therefore more susceptible to mitotic inhibitors. The observation that the administration of 300 mg of heparin daily for seven days will induce telogen effluvium in virtually all subjects observed tends to minimize the importance of individual variations in patients. The conversion to telogen in these patients occurs a few weeks to a month or more after the heparin is given. Telogen percentage may rise to over 50%, but, as in the postpartum situation, actual alopecia is not often manifest. Perivascular collagen degeneration has been seen in some histological studies, but the significance of this, if any, is unknown.

Idiopathic Alopecias

Alopecia Areata: Although it may be somewhat arbitary to designate this disease as "idiopathic," and those previously discussed as "physiologic," there is reason for doing so. Infantile alopecia and telogen effluvium can be demonstrated in most individuals under the proper circumstances, and the change in the hair is sufficiently predictable to give credence to the pathogenic mechanisms proposed. Such relationships are not readily established in alopecia areata. It is clearly a disease entity and not just a physiological phenomenon. A single cause has not been established, but histologic observations attest to its basic inflammatory nature.

Alopecia areata has been the topic of several good reviews, the most recent and extensive of which is from the Mayo Clinic. The incidence of this rather common disease has been about 2 to 2½% in the patients of large dermatology clinics. It is especially common among children and teenagers. It usually appears as one or a few bald patches on the scalp, although it may involve the whole scalp or even the whole body. Severe cases are more common in children. It is asymptomatic and the skin, except for the absence of hair, looks normal. The appearance of a depression in the involved areas is probably due to the loss of hair mass. In most cases regrowth occurs within a few months, although there is usually one or more relapses before regrowth is permanent. Individual areas often relapse or regrow independently of others. Initial extensive involvement, occurring in very young children, and involvement in sites other than the scalp all portend a poorer prognosis for eventual regrowth. Permanent regrowth after total scalp alopecia occurs in only 10% of adults and hardly ever in children. Regrowth typically

begins as pale vellus-type hairs that gradually assume the morphologic features of the surrounding hairs. In alopecia areata there are sometimes associated changes in other ectodermal structures. Pitting or brittleness of the nails occurs in 4 to 13%. Posterior subcapsular cataracts have been seen occasionally in adults. About 4% have vitiligo and about 8% have various thyroid gland disorders.

Most studies indicate a familial incidence of around 20%. However, rarely is the disease present in more than one relative. Also, considering the frequency of the disease, the significance of a 20% familial incidence is probably less than it might appear initially. Those who consider genetic factors of importance state that the pattern is probably autosomal dominant with variable penetrance.

Traditionally, emotional crises have been considered important at least in precipitating alopecia areata. Estimates of the degree of association between the two vary greatly. Studies of this alleged relationship are all too few and too limited in scope to be of much value.

Attempts to establish a hormonal basis for this disease have been generally unsuccessful. Relationship of the activity of the disease to pregnancy is unpredictable except in individual cases, where repeated remissions or exacerbations have occurred in repeated pregnancies. Apparently is has long been tempting to speculate on a thyroid dysfunctional cause. However, among the relatively frequent cases of thyroid disease are hypothyroidism, hyperthyroidism, endemic goiter, thyroiditis, etc., so that no thyroid hormonal pattern can be assumed. According to Rook, both hypothyroidism and hyperthyroidism tend to delay the onset of anagen phase and hence cause an increased telogen to anagen ratio.

Most sources of information on the histopathology of alopecia areata emphasize the following features: A chronic inflammatory reaction is seen around the lower one-third of the hair follicle, primarily around the bulb. The dermal papilla begins to lose the strong staining reaction for alkaline phosphatase, which is characteristic of normal anagen follicles. The follicle becomes smaller so that it lies progressively higher in the dermis. Eventually the whole structure is abortive and produces little or no hair. A thickened connective tissue sheath remains behind as evidence of what was once a normal anagen follicle. At this time the appearance is much like that of an ordinary telogen follicle except for inflammation around the bulb. The hair root is pointed rather than clubbed like a normal telogen hair.

Further observations of alopecia areata have revealed other similarities to telogen effluvium. Biopsies of the scalp at sites distant from lesions of alopecia areata, where the hair appears normal grossly, have revealed decreased normal anagen hairs, slight perivascular inflammation and areas of abortive follicles typical of alopecia areata. Similar but more pronounced changes, plus increased numbers of telogen follicles, have been seen in biopsies from the borders of alopecic lesions. Grossly these borders show thin, often broken hairs, that are narrowed at their insertion, resembling exclamation points. Thus alopecia areata seems to represent a combination of "telogen alopecia" and "dystrophic anagen alopecia."

Cormia and Ernyey have emphasized vascular occlusion as a possible pathogenetic factor. They feel that even though the inflammatory reaction seems to be the first recognizable event, vascular occlusive changes secondary to this may be the actual cause of the follicular shrinkage. They observe that in severe alopecia areata, ie., alopecia totalis, very little blood supply remains, especially around the bulb. Ikeda has also observed small artery occlusion followed by thrombus formation early in the course of alopecia areata. With the regrowth of hair, whether spontaneous or hastened by intralesional injection of a corticosteroid, the inflammatory infiltrate resolves, the blood supply increases and the follicle returns to a normal anagen appearance. Although this evidence favors some vascular occlusive process in alopecia areata, such changes are not peculiar to this disease. In fact, most types of alopecia show histologically some decrease in blood supply. However they do not appear to be directly related to an inflammatory infiltrate as they do in alopecia areata.

Intralesional injection of corticosteroids, preferably of the insoluble types, is the best treatment presently available for alopecia areata. It appears that this treatment probably does not alter the ultimate prognosis but simply hastens regrowth in those lesions where regrowth is due in the future. Unfortunately, intralesional steroid injection is sometimes attended by complications. The usual ones are not ordinarily serious. Subcutaneous injection sometimes produces a temporary subcutaneous fat atrophy. Intradermal injection sometimes causes dermal atrophy which may be

permanent. The most serious complication has been reported from France. Three young women whose anterior scalps were being injected for alopecia developed sudden blindness with head and eye pain. It was reasoned that forceful injection of a steroid particle suspension (Depo-Medrol® in two cases) entered a branch of the superficial temporal artery. From here there was retrograde flow into the anastomosing supraorbital branch of the ophthalmic artery and on into the ophthalmic artery, thence to the central retinal-artery where sudden occlusion occurred. Obviously injection into the scalp must be done carefully, despite the rarity of this complication.

Pseudopelade (Brocq, 1885): Discussions of this type of baldness are usually characterized more by disagreement than by elucidation. The disagreement stems from the question of its existence as a discreet entity. Contrary to the original description of the disease as a primary, atrophic, scarring alopecia, some have preferred to think of it is secondary to lichen planus or discoid lupus erythematosus or something else.

The usual characteristics of pseudopelade are a patchy and confluent, insidious, asymptomatic, atrophic and cicatricial alopecia, according to Laymon and Murphy's description. It is seen in adults, mostly women, and is progressive and irreversible. The alopecic areas are depressed and glossy with obliteration of follicular orifices. Most observers recognize a faint erythema at the borders. Sometimes the differentiation from alopecia areata (syn. *pelade*) is not so clear as the classical description of pseudopelade implies. Histologically there is inflammation in the upper portion of the hair follicle with eventual destruction and obliteration of the follicle.

Regarding the disagreement over the status of pseudopelade, it matters little whether Brocq's original cases represented truly a primary process or the residual of some inflammatory condition. The diagnosis is made entirely on *morphologic* grounds, and the scope of the diagnosis must be narrowed as *etiologic* information is gained about various alopecias that may produce what some have called the "pseudopeladic state." As causes are discovered these alopecias must be removed from the pseudopelade category.

Hereditary-Patterned Alopecia

This term refers to the very common frontal and occipital balding that begins at sexual maturity in men, and in women around the menopausal age, the so-called "diffuse female alopecia." In the male especially, the distribution of this alopecia differentiates it from others. There is progressive hair loss in the frontoparietal areas and, to a lesser degree, in the frontal area, and hair loss in an oval configuration at the crown. These areas often merge to produce the familiar marginal "horseshoe" of remaining hair.

It should be realized that there is normally a limited frontal and parietal recession of the hairline in nearly all persons after puberty. Although this is hormonally induced it is separate from true patterned alopecia.

Diffuse alopecia is the female counterpart of patterned alopecia in males. There is a less severe progressive hair loss in the vertex and frontoparietal areas, and this is usually first observed as an increased amount of hair clinging to the hair brush. This may be gradual or intermittent, and the hair may become less manageable. Some patients notice increased oiliness of the scalp. There may be vague symptoms of tingling, itching, or a crawling sensation of the scalp. In most cases there is no significant regrowth. In neither men nor women is there complete baldness. Close inspection always reveals considerable numbers of fine, short, pale vellus hairs on the apparently bald areas. Quacks often take advantage of the fact that patients do not notice these hairs, and point them out as evidence of hair growth after whatever treatment has been given.

There are three prerequisites for the development of hereditary-patterned alopecia in both males and females: (1) the presence of sufficient circulating levels of androgens, ie., sexual maturity, (2) the genetic predisposition (autosomal dominant, incomplete) to develop the condition, and (3) the age of late adolescence or older.

Eunuchs and hypogonadal females do not develop this alopecia because they lack testicular and ovarian androgens respectively. Apparently adrenal androgens are insufficient to induce the condition. With proper hormonal replacement therapy, and with the genetic predisposition, these people would develop alopecia. Since the inheritance is dominant, both heterozygotes and homozygotes are involved. It tends to be more severe in the latter.

Histologically there is progressive shrinkage of follicles and hairs in a random fashion. The conective tissue sheaths of follicles remain behind. The anagen period is shortened, resulting in shorter hair growth and more telogen hairs. Even-

tually only tiny vellus hairs are produced from miniature follicles, and many follicles have completely degenerated. The sebaceous glands remain, and are proportionally enlarged if not actually enlarged. There is a general reduction in blood supply to the scalp in patterned alopecia as there is with increased age normally. This has not been shown to be a causative factor.

Papa and Kligman were able to induce regrowth of perhaps 10 to 15% of terminal scalp hair in bald men of various ages by rubbing 1% testosterone propionate ointment on the scalp. Others have been unable to duplicate their results. The paradox is apparent here, that circulating androgen induced the baldness in the first place and topical androgen seemed to reverse it. Obviously the local effects on the hair follicle must be pharmacologic rather than physiologic. Testosterone propionate is apparently well absorbed percutaneously, and could theoretically at least cause pituitary inhibition. There has been considerable interest recently in the surgical treatment of hereditary-patterned baldness by the multiple-punch graft technique. The various aspects of this treatment have been discussed at length.

Studies on urinary androgen excretion in women with diffuse alopecia have not been impressive generally. However, one study has revealed significantly elevated urinary testosterone excretion in 30 women with diffuse alopecia when compared to control levels. Considerable attention has been given to possible thyroid dysfunction in women with diffuse alopecia. There is little evidence to support such a relationship and those allegations have been primarily on observations that some patients have seemed to improve while taking thyroid. It is well recognized that myxedematous persons tend to have sparse "coarse" hair and rough scaly skins. Careful studies of these observations are also lacking. The impression of coarseness is probably due to dryness. Thyroid hormone deficiency apparently does cause a slowing of mitoses in the skin with retention of stratum corneum and a decreased sebum production. The sparseness of the hair probably reflects decreased mitosis in the hair matrix and breakage of hair shafts.

Chapman and Main have reported diffuse thinning of scalp hair in two post-menopausal women who were hypothyroid from long-term iodide therapy for asthma. The patients became euthyroid and grew their hair again after discontinuing the iodides.

Traction Alopecia

This fairly common type of alopecia is seen principally in women and girls who repeatedly roll their hair tightly on brush rollers or who wear their hair in braids, pigtails or a bun. In each of these situations the hair in various places is subjected to long periods of firm traction. As a result, hair is either slowly pulled out or stretched or broken. Apparently no histologic studies are available to indicate whether the traction induces a premature telogen phase or inflammatory reaction, or whether the hair is simply pulled out and the remaining matrix cells continue to proliferate and produce a new hair.

The areas affected depend, of course, on the site of the greatest traction. With ponytails and buns the greatest traction is marginal, ie., along the temporal and retroauricular borders. With braids the midline of the scalp sagitally also is affected. Brush rollers induce alopecia in multiple patches, marginally, sagitally and at the frontal border. Close inspection reveals various degrees of hair loss in the various patterns, short tapered hairs of new anagen growth, and broken hairs. Occasional folliculitis may be seen but the scalp otherwise appears normal. If the trauma is discontinued regrowth usually is complete in three to four months, although scarring from folliculitis and severe trauma may cause some permanent loss.

Savill has observed that similar problems result from the use of hair brushes with sharp-edged bristles. Apparently vigorous and frequent brushing can cause fracturing, fraying and even extraction of hair. Brushes with natural rather than synthetic bristles are less likely to cause this.

Miscellaneous Traumatic Alopecias

Certain rare, sometimes familial, structural abnormalities of the hair, including *trichorrhexis nodosa* (intermittently splintered hair), *monilethrix* (beaded hair) and *pili torti* (twisted hair), are characterized by fragility and breakage of the hair of the scalp and other areas with minor trauma. These abnormalities are sometimes parts of congenital neuroectodermal syndromes, and have been linked with arginosuccinic aciduria, an abnormal urinary amino acid excretion pattern. However, recent studies have shown, in the case of trichorrhexis nodosa, that the urine is usually normal, the patient is healthy, and that the

splintering and fracturing are caused by trauma especially brushing, teasing, and scratching. In fact this abnormality can be produced in normal hair *in vitro* by subjecting it to artificially controlled manipulation of a specific type.

The problem of *trichotillomania* (pulling of hair by the patient) is not encountered frequently but is a difficult management problem. Patients are usually loathe to admit that they have pulled out or broken their hair as a result of some nervous habit or psychoneurosis. Indeed, they may not even be aware of it. The appearance is usually that of broken hairs and loss of hairs in one or more areas where the patient has continually pulled or twisted or curled the hair around a finger or scratched the scalp. The areas involved cannot be explained on the basis of brush rollers or other cosmetic procedures. The treatment is directed at convincing the patient of the nature of the difficulty, and sometimes the use of psychotherapeutic measures. The problem may be solved by having the patient wear a wig so the hair is not easily accessible.

Postoperative pressure alopecia has been listed as a distinct entity. Abel and Lewis reported eight cases in young and middle-aged women. These women had been on an operating table in the Trendelenburg position, for six hours or more in most cases, for gynecologic surgery. As a result of continuous pressure on the supraoccipital area there was rapid hairloss in this area from 3 to 28 days postoperatively. Most of the patients had been hypotensive for a time during surgery. Five of the eight had edema and exudation of the affected area within two days. Otherwise the patches resembled alopecia areata. Regrowth occurred in all cases within three months.

The histological findings were interesting. The outstanding change was an obliterative vasculitis of the middle and lower dermis, along with shrinkage and shortening of the hair follicle. A perivascular chronic inflammatory infiltrate was seen and in two cases panniculitis occurred. A similar alopecia has been observed over lumps in the scalp, in bruises, and in areas of furunculosis where scarring was minimal.

Post-Inflammatory Alopecias

Included in this category are those situations in which inflammation has been severe enough to cause destruction of the hair follicles and scarring. Some have been discussed already under other headings. However, one of these, alopecia mucinosa, is a unique entity with possibly serious implications and deserves special mention.

Alopecia mucinosa was described by Hermann Pinkus in 1957, from observations on six cases. These patients had one or more alopecic plaques on the head and extremities. The plaques were of slow onset and progress, yellow-brown, variably indurated, usually with patulous follicles and fine scale, and were asymptomatic. Children and adults of both sexes were involved. Histologically there was mucinous edema of the hair follicles and sebaceous glands until the whole pilosebaceous apparatus became an edematous bag. There was variable chronic inflammatory infiltration with secondary destruction of parts of the follicle. Pinkus believed the disease was basically inflammatory. However, Kim and Winkelmann state that the mucinous infiltration usually precedes the inflammatory reaction.

Five years later Pinkus discussed the followup of his original cases and compiled information on 63 additional cases from the literature. Some lesions appeared as groups of follicular papules. Some follicles were plugged rather than patulous, and contained stubby hairs. Still other lesions were moist and appeared eczematous. Hypesthesia was reported in some. Histochemical studies revealed increased amounts of glycogen in the follicles, and indicated that the mucinous material was acid mucopolysaccharide and mucoprotein. Most cases were self-limiting within a few months but in a few, an association with lymphoma was seen. Four of the patients either developed lymphomas or their alopecia mucinosa was secondary to pre-existing lymphomas. One-half of all the cases were under the age of 30, and one-third were in the 11 to 20 age group. Half had more than two lesions. In a later discussion, the clinical appearance has been divided into three categories: (1) like lichen spinulosis (groups of follicular papules with stubby hairs), (2) coalescent follicular papules with an eczematous surface, and (3) red boggy infiltrated plaques. The first type is the most common and most benign. The second and third types are seen in adults only, are more chronic, and have a denser inflammatory infiltrate. These types include those that are lymphomatous, which, according to Braun-Falco, always occur in patients over 40 years of age, and constitute less than 5% of all cases. In the cases reported by Kim and Winkelmann, some lesions changed from that of grouped follicular papules to plaques. Also, in

40% of their cases alopecia was not prominent. The scalp was involved in 25% of their cases.

Treatment with topical cortocosteroids or superficial X-ray have been effective in some cases. In those cases secondary to lymphoma, the treatment is that of the primary disease.

Alopecias Due to Mitotic Inhibitors

Almost any antimitotic drug, alkylating agent or otherwise, may cause alopecia if given in sufficient amounts. The worst offenders are vincristine, cyclophosphamide, and 5-fluorouracil. Since these drugs affect only actively dividing cells, the resulting alopecia can be called "anagen effluvium." However, local application of colchicine may induce a change to telogen phase. Smaller amounts of mitotic inhibitors will cause only a temporary suppression or cessation of mitosis. The result is a constriction in the hair shaft, of such length as to reflect the period of effect of the drug, but the hair cycle is not materially altered. Heparin-induced alopecia already has been discussed in the context of induction of the telogen phase. This drug is also a mitotic inhibitor and may cause alopecia in this way also. The coumadin compounds, heparinoids, paritol and dextran sulfate also cause alopecia. Apparently the mechanisms by which these compounds inhibit mitoses or induce telogen has not been elucidated.

An ingenious method has been devised by which alopecia from intravenous antimitotic drugs can be inhibited. A special sphygmomanometer cuff is placed on the head just below the scalp margins and is inflated to above systolic pressure. The blood supply of the scalp is thereby occluded during and for five minutes after intravenous administration of the drug.

Miscellaneous Alopecias

Several years ago a hypocholesterolemic agent, MER/29 (Triparanol®) enjoyed brief popularity. It soon became apparent, however, that a large percentage of the patients receiving this drug developed side effects, the most notable of which was ichthyosis. Subsequent to this some patients developed progressive diffuse alopecia of the scalp, eyebrows, and pubic hair. The process was reversible when the drug was discontinued. An analysis of the cases from the Mayo Clinic indicated that 250 mg of the drug daily would not cause alopecia but that 750-1000 mg daily nearly always did. The mechanism of this process was never elucidated. An antimitotic effect is unlikely because eyebrow and pubic hair grow quite slowly and are seldom affected by known mitotic inhibitors. A more likely explanation is defective keratin synthesis since the drug interferes with the synthesis of cholesterol, a significant component of keratin. The defect possibly was simply more obvious in the scalp, eyebrows, and pubis since hair is present in greatest density in these areas.

Another well-recognized cause of alopecia is thallium poisoning. Thallium acetate has been used in the past for epilation in treatment of ringworm of the scalp. However, it is not regularly effective in removing all the affected hairs; furthermore, its great toxicity makes it unsuitable for therapeutic use. In fact, its principal use now is as a rodenticide. Its toxic effects are cumulative and are similar to those of lead. It is slowly excreted in the urine and bile.

Ingestion of 7-8 mg/kg body weight causes anagen effluvium of an unphysiologic sort, with intrafollicular breakage of scalp hair and a high rate of conversion to catagen phase. With subsequent hair growth, as in other situations of excessive catagen and telogen conversion, a compensatory pause to reestablish non-synchronous cycles must be assumed.

An interesting phenomenon is the occurrence of patchy alopecia on a clinically normal appearing scalp in patients with cutaneous metastatic disease, especially from the breast. This has occurred with intraductal and scirrhous carcinomas and with ordinary adenocarcinoma. A resemblance to alopecia areata is apparent in early stages, but later the lesions tend to become red, nodular and indurated. Here it is possible that tumor cell infiltrates of blood and lymph vessels not yet clinically visible are of sufficient extent to compromise the blood supply of hair follicles, or perhaps to destroy their matrices.

Conclusion

The foregoing remarks for the most part have stressed the pathogenesis of various clinical types of alopecia. Notable is the great similarity of pathogenetic mechanisms among greatly dissimilar clinical patterns. The conclusion is that regardless of what pathophysiology causes the alopecia, the response mechanism of the hair follicle tends to be the same or similar.

Management and assessment of prognosis must still be based largely on clinical diagnosis.

A complete list of references will be supplied upon request.

A GAMUT OF "COLLAGENOSES"

The concept that the collagen diseases are variant symptom complexes of a basic immunologic disorder is being widely accepted. The case presented strongly supports this hypothesis by running the gamut from the mildest to the most severe manifestations of the "collagenoses."

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The patient is a 29-year-old white married woman who was admitted to the hospital January 4, 1965 complaining of pain and tightness in the left chest, shortness of breath, fever, generalized aching, weakness and nausea which had become progressivley more severe for three days.

She was first observed in June, 1943 at age six. She was then living with her step-father who had active pulmonary tuberculosis, and her mother who had mild diabetes. The patient's tuberculin was 4+. In November, 1943, she had tonsillitis with a culture positive for beta hemolytic streptococci and in June of the following year, a T and A was performed.

In June, 1947, the patient developed acute hyperthyroidism. This was controlled by propylthiouracil for three years. During this period, diabetes mellitus appeared and was controlled by 25 units of PZI daily.

She grew normally and started menstruating at 14½ years. Insulin had to be increased to 75 units by 1954. In January, 1956, during her first year of college she developed erythema nodosum after which she frequently had morning stiffness of the knees. However, her corrected sedimentation rate remained under 20.

In November, 1957 she was married. The patient then weighed 120 pounds and was controlling her diabetes with 25 units of lente insulin.

She developed symptoms of Raynaud's disease of the fingers of both hands and aching and stiffness of the wrists and knees in October of 1959. During the latter part of December and early in January, 1960, she had swelling of the feet and hands. Her weight was down to 106. She was afebrile, had a normal blood picture and sedimentation rate, and negative latex and L.E. preparation. The A/G ratio was 3.6/3.4. The EKG was normal.

By June, 1960, Scleroderma of the forearms was obvious. The corrected sedimentation was now 25, and L.E. preparation negative. In July, the patient was treated in the hospital for a hypoglycemic convulsion. Three days later she developed a left facial paralysis which cleared spontaneously in one month.

Ulceration of the sclerodermatous right index finger developed in January, 1961, but healed after three months. By June, 1962, her weight had dropped to 86 pounds because of dysphagia. Thereafter, the sclerodermic G-I dysfunction subsided, her nutrition improved and by October, 1964 she weighed 105 pounds.

The physical examination showed an emaciated acutely ill young woman with butterfly flush over the malar regions and bridge of the nose. The skin of the lower arms and entire forearms and hands had the brawny and fixed character typical of

scleroderma. The fingers were almost completely ankylosed in a semi-fixed position. The lungs showed fine rales over both lower lobes. The heart sounds were clear and regular. The pulse was 110 and B-P 110/70. The ankles were swollen and showed a 2+ edema.

The urine showed 3- albumin, no sugar and 6-10 W.B.C. The hemoglobin was 10.1 gms, hematocrit 32, W.B.C. 10.100 with neutrophiles 85%, stabs 4%, and lymphocytes 11%. The F.B. glucose was 110 mgs%; S.U.N. 9 mgs%. The latex and L.E. preparations were positive. The A.G. ratio was 3.1/3.2. X-ray of the chest showed passive congestion and rather marked increased transverse diameter of the heart. The EKG showed low amplitude of QRS in the standard leads, measuring 3mm in I and 2mm in II, an ST segment elevation of concave configuration 1-2 mm in the standard leads and AVF and V5 and V6 and the R in V3 was 0.5mm in the presence of an R of 1mm in V2. The impression was possible pericarditis or non-specific myocardial changes.

The temperature peaked daily to 102 until intra-muscular dexamethasone was given. The fever then disappeared within 4 hours, and with it went all the other subjective symptoms. The rales also disappeared. Her appetite returned, and Prednisone was then given orally and was titrated to 30 mg per day. Insulin regulation was somewhat difficult because of the diabetes but was finally accomplished. She was discharged in 2 weeks with the diagnosis of acute lupus erythematosis, scleroderma, and diabetes mellitus.

The patient did well except for a bout of Herpes Zoster of the right 4th thoracic segment in June 1965. At last observation, October 1965, the patient weighed 106 pounds, was completely ambulatory, did her own housework, drove a car and played the piano. She was taking 15 mg of Prednisone and 80 units of lente insulin daily.

Tuffanelli and Winklemann reviewed 727 cases of systemic sclerosis seen at the Mayo Clinic between 1935 and 1958. They found 36 cases with both scleroderma and dermatomyositis, 31 cases of scleroderma and rheumatoid arthritis, 5 cases of scleroderma and lupus erythematosis, 7 cases of scleroderma and 2 of Sjögren's Syndrome.

They also reviewed literature concerning the presence of auto antibodies in the "collagenoses." Auto antibodies in lupus erythematosis is recognized everywhere and Damoshek calls it "an auto immune disease par excellence." Bardewil, through fluorescent antibody techniques, demonstrated the presence of a circulatory antibody in the gamma globulin fraction of 6 cases of scleroderma, 5 of lupus, 2 of dermatomyositis and 8 of rheumatoid arthritis which reacted with intranuclear nucleo proteins in autologous and homologous tissues.

The small Rheumatoid factor is another abnormal gamma globulin which has been found in many scleroderma patients, as it was in this case. Corcos, in 28 cases of scleroderma, found 7 with hypergammaglobulinemia, 13 with positive latex fixation tests, 6 with positive sheep cell tests, and 9 had fixed complement with calf thymus nuclei.

Hashimoto's thyroiditis was the first human disease proven to be caused by auto immune mechanisms. Becker, in reviewing the association of connective tissue diseases and symptoms with Hashimoto's disease, found a tenfold increase in the incidence of rheumatoid arthritis as compared to patients with granulomatous thyroiditis. There were also cases of scleroderma, Sjögren's disease and lupus erythematosis in the Hashimoto group.

Finally, there is a great deal of evidence to show that the so-called "collagen diseases" are not distinct entities but are variant or transitional forms of auto immune disturbances.



MEDICAL NEWS

From Baltimore . . . William Stewart, MD, recently appointed assistant professor at the University of Maryland School of Medicine, is helping to establish a new division of family practice which he hopes will revive the image of the family doctor making house calls—an image that has all but disappeared from the American scene.

"A survey taken three years ago," Dr. Stewart said, "indicated that more than 50% of freshman medical students wanted to become GP's. But," he added, "when they graduate, only 15% actually go into general practice.

"I believe the percentage drops because students are not exposed to general practice in medical school. How can they be expected to maintain their interest when they are taught only by specialists?

"The medical profession must remain responsive to the needs of the people, and the need today is for more doctors who can give total care. Many people use hospital emergency rooms as their family doctors, which is one reason for the crowded conditions of emergency rooms. The non-emergency patient often must wait hours before being seen. This is one of the problems we hope our family practice program will help solve."



Dr. Stewart

Dr. Stewart, the first full-time general practitioner appointed to the medical faculty, will begin the division next year on the graduate level with five residents participating in a three-year program. The residents will spend most of their time giving outpatient and ambulatory care in an adult center similar to the University of Maryland's Community Pediatric Center.

Outlining the duties of the residents, Dr. Stewart said, "Each resident will have a certain number of families in his care. He will make house calls, give yearly physical examinations to each member of the family, and evaluate home situations. By working with public health nurses, social workers, and others in the health field, the residents will be part of a team approach to medical care. We want to produce a physician who is family- and community-oriented rather than disease-oriented."

Maryland's School of Medicine is the tenth in the nation to initiate a division of family practice. At its annual meeting last fall in Dallas, the American Academy of General Practice voted to make family practice a board-certified medical specialty with a required re-examination by the specialty board for certified doctors every six years.

As vice president of the Maryland Academy of General Practice, Dr. Stewart stated that re-examination is vital. "The advances in medicine make it imperative for doctors to keep up-to-date. I believe the day is coming when all specialties will require recertification."

Dr. Stewart was awarded BA and MD degrees from The Johns Hopkins University and has been in practice in Westminster since 1952. He is a member of the Maryland State Board of Examiners and is chairman of the liaison committee of the state medical society.

Lincoln Gordon, PhD, was installed as ninth president of The Johns Hopkins University on February 22, 1968, at a formal ceremony coincident with the 92nd anniversary of the founding of the University.

A former Assistant Secretary of State of Inter-American Affairs, Dr. Gordon is a political economist and foreign affairs expert. He is a graduate of Harvard University where he was elected to Phi Beta Kappa and became a Rhodes Scholar. He received his doctorate from Oxford University in England.

In between his tenures at Harvard, where he

occupied a prestigious professorial chair, he served in Washington with various agencies during and after World War II and was a major participant in the formulation of the Marshall Plan for European Recovery and the Alliance for Progress with Latin America plan. Prior to his appointment with the State Department, Dr. Gordon served as Ambassador to Brazil.

In announcing Dr. Gordon's election, Charles S. Garland, Chairman of the University's Board of Trustees, said, "Dr. Gordon is an outstanding scholar of demonstrated accomplishment who himself has served as a senior professor at one of our most distinguished sister institutions; he is a superbly skilled administrator with a rich and varied background, so vital in running the affairs of a modern, complex university; and he is an articulate, dedicated man who has devoted his life to the service of mankind and the pursuit of knowledge."



Dr. Gordon

Dr. Gordon is author, co-author or editor of eight books. He has been a trustee of the World Peace Foundation, the Center for International Economic Growth and the Longy School of Music. He is a fellow of the American Academy of Arts and Sciences and a member of the American Economics Association, the Council on Foreign Relations, and the Royal Economic Society. He was granted the honorary degree of Doctor of Laws by Fairleigh-Dickinson University in 1965, Rutgers University and Columbia University in 1967.

The institution President Gordon is heading is one of the smallest of America's senior universities in terms of student enrollment, but one of the most complex in the scope of its activities. Undergraduate enrollment is 1,810; upper division students amount to 2,367 with more than 800 post-doctoral fellows.

With an annual budget in excess of $130 million, the university operates on five campuses—the Faculty of Arts and Sciences located at Homewood; the School of Medicine and the School of Hygiene and Public Health in East Baltimore; the School of Advanced International Studies in Washington, D. C., with its branch in Bologna, Italy; and the Applied Physics Laboratory in Howard County, a U. S. Navy contract research organization.

From Chicago . . . Karl Menninger, MD, founder and developer of the Menninger Clinic and Menninger Foundation, has been appointed the first Distinguished Professor of Psychiatry for the University of Health Sciences/The Chicago Medical School. In this capacity, Dr. Menninger will lecture and act in an advisory capacity in psychiatry at the institution.

The University of Health Sciences, a new approach to health care education, was officially launched on November 9, 1967, with The Chicago Medical School, a long-established medical teaching institution, as its base.

Commenting on the concept of this first university of health sciences, Dr. Menninger said, "It's a great idea and a great ideal and I am looking forward to being part of it."

Dr. Menninger is also senior consultant to the Stone-Brandel Center in Chicago, chairman of the Board of Trustees of the Menninger Foundation and dean of the Menninger School of Psychiatry in Topeka, Kansas. He serves as a consultant to the Veterans Administration, the U. S. Department of Justice—Prison Service, the U. S. Department of Health, Education and Welfare—vocational Rehabilitation, the Kansas Board of Social Welfare—Institutional Management, the Committee on the Rights of the Mentally Ill of the



Dr. Menninger (c.) is congratulated by Herman M. Finch (l.) chairman of the board of trustees, University Health Sciences/The Chicago Medical School, and University President, Walter S. Wiggins, MD.

American Bar Foundation, the Forbes Air Force Base Hospital, the Topeka State Hospital, the Topeka Veterans Administration Hospital, the Kansas Diagnostic and Reception Center, the Kansas Neurological Institute, and the Aspen Institute of Humanistic Studies in Colorado.

The world-renowned psychiatrist is a member of the Chicago Committee of the Chicago Council on Foreign Relations, the Family Study Commission of the Illinois Legislature, and the Cook County Sesquicentennial Committee of Illinois, and the Board of Directors, Chicago Boys Clubs.

In 1965, The American Psychiatric Association presented its first Distinguished Service Award to Dr. Menninger.

The National Easter Seal Society for Crippled Children and Adults has announced two scholarship programs for students in rehabilitation fields.

The programs are sponsored by two women's sororities, Alpha Chi Omega and Kappa Delta Phi.

The Alpha Chi Omega program of supplemental aid scholarships is a new project to assist students working toward master's degrees in speech pathology or audiology. Kappa Delta Phi scholarships are for students in their last year of training as physical or occupational therapists.

The Kappa Delta Phi Scholarships will range from $100 to $500. Applicants must be accepted in a certificate course or be in the senior year or the clinical training period of a degree course in occupational or physical therapy in a school approved by the Council on Medical Education and Hospitals of the American Medical Association.

Applications will be considered by a scholarship committee on the basis of scholastic achievement and financial need. Deadline for application is May 1, 1968.

The Alpha Chi Omega scholarships will be granted in amounts up to $750 toward a student's support during the course of a full academic year. The student must be recommended by the department head or a ranking faculty member of a master's degree program accredited by the American Speech and Hearing Association.

Deadline for application is July 15, 1968.

For more information, write to Scholarship Coordinator, Educational Service, National Easter Seal Society for Crippled Children and Adults, 2023 W. Ogden Ave., Chicago, Ill. 60612.

From Philadelphia . . . The American College of Physicians is anticipating the attendance of 5,000 specialists in internal medicine at its 49th Annual Session, April 1 to 5 in Boston.

The five days of scientific sessions will include 28 sessions with presentations of original papers covering advances in cardiovascular diseases, gastroenterology, pulmonary disease, endocrinology and metabolic disorders, rheumatology and immunology, infectious diseases and allergy, hematology, kidney diseases, neurology, psychiatry and cancer.

In addition, 14 panel discussions on major issues in clinical medicine will be held.

The annual session will also include a business session of the College, social events, including a concert by the Boston Symphony Orchestra and the President's reception and dinner dance. The session is being planned by Rudolph H. Kampmeier, MD, Nashville, Tenn., ACP President and Professor of Medicine Emeritus at Vanderbilt University School of Medicine, assisted by a local committee headed by Daniel S. Ellis, MD, of Boston, Assistant Clinical Professor of Medicine at Harvard University School of Medicine.

The Philadelphia Museum of Art is planning an international medical art center of prints and related illustrative medical material with an accompanying research reference center.

The complex, to be known as ARS MEDICA CENTER, was made possible through a major grant from the Smith Kline & French Foundation, the educational and scientific trust of SKF Laboratories, Philadelphia.

Development plans include the expansion of the Museum's outstanding collection of prints and drawings relating to the medical sciences, and the creation of a center for pictorial research in subjects pertaining to the history of medicine and allied professions. Through an informational retrieval system, both the original and some non-original visual material such as photographic archives, slides, etc. will be readily accessible for reference, study, exhibition, and loan.

Administration of the ARS MEDICA CENTER will be under the direction of Kneeland McNulty, Curator of the Department of Prints and Drawings.

The Heart Page

CHRIS PAPADOPOULOS, MD, EDITOR

A service of the Heart Association of Maryland

New Methods for the Prevention and Treatment of Ventricular Arrhythmias

Ventricular arrhythmias may cause serious disturbance of cardiac function and may result in death if not quickly terminated. In the past few years, reliable methods of terminating and preventing ventricular arrhythmias have been developed. These include external electric cardioversion, artificial pacing and the use of drugs including lidocaine (Xylocaine), diphenylhydantoin (Dilantin), and propranolol (Inderal).

J. O'NEAL HUMPHRIES, MD
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine

Lidocaine

Lidocaine may be used subcutaneously as a local anesthesia, but when given intravenously it has a potent anti-arrhythmic effect. Its mechanism of action is very similar to that of quinidine or procaine amide; suppressing cardiac excitability. Like quinidine and procaine amide, lidocaine slows conduction, diminishes the force of contraction, and causes peripheral vasodilation. In large doses, it may cause excessive stimulation of the central nervous system and result in restlessness or even grand mal seizures. Lidocaine is not antigenically related to quinidine or procaine amide.

Lidocaine may be indicated for frequent premature ventricular contractions (PVC's), complicating an acute myocardial infarction or injury, for multifocal or pairs and triplets of PVC's occurring in a variety of situations, and for recurrent episodes of ventricular tachycardia. An initial dose of 100 mg of undiluted lidocaine should be given intravenously in three to five minutes followed by a maintenance dose of 100 mg per hour. This may be diluted in saline or in glucose and water and given as a slow intravenous drip. If the maintenance dose of 100 mg per hour successfully controls the ventricular irritability, attempts to progressively and slowly reduce the dose to 50 mg or less per hour should be made. If 100 mg per hour is not successful in suppressing the arrhythmia, the dose may be increased to 200 or even 300 mg per hour. If central nervous system irritation develops, the dose must be reduced and barbiturates administered. Lidocaine can be given continuously for days, or even weeks, if necessary.

In most circumstances, quinidine or procaine amide should be started orally as the dose of lidocaine is reduced and discontinued.

The very short duration of action of lidocaine when administered intravenously is in marked contrast to the duration of action of procaine amide or quinidine. It is this characteristic which makes lidocaine such a useful drug in the management of acute arrhythmias. The onset and peak action is almost immediate; it exerts its effect for three to six minutes and then the effect wanes

rapidly. The effect is dissipated in most persons in ten minutes and in everyone in 20 minutes.

Propranolol

Propranolol blocks the beta-adrenergic receptors in the heart and elsewhere in the body and thus reverses catecholamine effects; the sinus rate is reduced, conduction slowed, and excitability diminished. In large doses, propranolol appears to have a "quinidine-like" action of its own in addition to its beta-adrenergic blockade action. These actions are synergistic. Unfortunately, the blockade of the beta-adrenergic receptors significantly reduces myocardial contractility, and large doses of propranolol in the normal heart or therapeutic doses in the diseased heart may result in hypotension and heart failure. Also, bronchospasm may be markedly increased by the drug. Nevertheless, propranolol has been successfully used to treat and prevent ventricular irritable rhythms. It has been especially useful for the treatment of ventricular arrhythmias induced by digitalis. In an acute situation 0.5 to 1.0 mg should be given intravenously over ten to twenty seconds and may be repeated four or five times every three to five minutes. If the results are desirable, the drug may be continued by the intravenous route or may be given orally. Ten mg every six hours is the usual beginning oral dose. This can be increased gradually to 40 mg or more every six hours if indicated. The effect persists for four to eight hours after an intravenous or oral dose.

Propranolol has been useful where the suppressive agents, lidocaine, quinidine, or procaine amide have not been successful in controlling the recurrence of the ventricular irritable rhythms.

Diphenylhydantion

While diphenylhydantoin shares most of the cardiovascular actions of quinidine it does not slow conduction in the ventricle and thus is especially useful in the treatment of ventricular arrhythmias provoked by digitalis. One hundred mg may be given intravenously over a period of ten to twenty seconds, and may be repeated four or five times at five to ten-minute intervals if necessary. Doses larger than 500 mg have not proved effective and may be hazardous. If desirable effects result, diphenylhydantoin may be continued orally 100 mg three or four times a day.

Numerous instances of diphenylhydantoin causing severe and lethal slowing of the heart have been reported. This effect has usually occurred when large intravenous doses were being given rapidly. Therefore continuous observation of the heart rate and rhythm is mandatory when the drug is being given intravenously. Although diphenylhydantoin has been advocated in some instances of digitalis intoxication, the preferred management of digitalis intoxication continues to be the withdrawal of digitalis and when indicated the administration of potassium. Diphenylhydantoin should be given only when ominous ventricular arrhythmias are present.

Artificial Pacemakers

In the presence of complete heart block with a slow idioventricular rhythm or even in the presence of marked sinus bradycardia, the use of the suppressive and beta-adrenergic blocking agents to treat ventricular irritability may be hazardous. Ventricular arrhythmias occurring under these circumstances can be prevented by increasing the heart rate to physiologic ranges with an artificial pacer. Once reliable pacing is established, the suppressive and beta-adrenergic blocking agents can be used if necessary.

More recently, artificial pacing has been recommended to prevent ventricular arrhythmias even in the absence of bradycardia. An occasional patient with a normal heart rate and mechanism will continue to experience episodes of ventricular tachycardia despite the vigorous use of drugs but will cease to have these bouts if the heart rate is increased to 90—120 per minute with a pacemaker. In the absence of heart block, the pacing can be accomplished by placing a catheter electrode in the right atrium, but ventricular pacing from a catheter electrode in the apex of the right ventricle is usually more reliable. Temporary pacing may suffice for recurrent tachycardias resulting from drug toxicity or an acute myocardial infarction, but permanent pacing is needed in less well circumscribed situations. In either case, it is often necessary to continue to use suppressive and/or beta-adrenergic blocking agents in conjunction with the artificial pacemaker.

Baltimore City Health Department

Robert E. Farber, MD, MPH, Commissioner

New Medical Care Institutional Inspection Unit

The City Health Department has begun an intensive program to upgrade environmental conditions in those medical facilities in Baltimore City where patients on the Medical Assistance Program are provided services or care. These medical facilities include hospitals, nursing homes, clinical laboratories, blood banks and ambulances.

The new program established by the Medical Care Services of the City Health Department is being conducted under the supervision of the Bureau of Environmental Hygiene. Three sanitarians, Philip A. Berman, William N. Glenn and Lloyd H. Ross, have been appointed to the new Medical Care Institutional Inspection Unit. Their work will involve continuing inspections and surveillance of medical care facilities on a regular basis. In addition, they will investigate sanitary complaints concerned with these facilities and participate in other related activities.

The new Medical Care Institutional Inspection Unit will work closely with the Nursing Homes Division of Medical Care Services and the Director of Local Health Services.

Poison Control Ledger Report

According to reports compiled from accident rooms of 20 Baltimore hospitals and clinics, 3,761 persons were treated for accidental poisoning in 1967, the majority of whom were city residents. This report was made possible by the new poison report form which was supplied by the Baltimore City Health Department to those city medical facilities where accidental poisonings are treated. The total poisonings from this report does not include cases cared for by private physicians or treated with first aid at home. The record also shows that 21 Baltimore residents died of poisoning in 1967.

As in past years, most poisonings occurred to the pre-school child. A total of 2,073 children one to five years of age were treated for poisoning and one 26-months old child died of lead paint poisoning. By far the leading group of poisoning agents was internal medicines with 2,465 cases, and the leading medicine was aspirin. The next highest group of poisoning agents were household preparations such as soaps, detergents, polishes and cleaners with 404 cases.

A further analysis of reported internal medicine poisonings shows that of 600 cases involving drug abuse or accidental poisoning by barbiturates and sedatives, 336 were persons from 13 to 29 years of age. Further, a report from the State Medical Examiner's Office indicated that 11 of 24 poisoning deaths in Maryland in the 13 to 29 age group were caused by narcotics, sedatives, barbiturates and tranquilizers.

Publicity for poison prevention in the Baltimore area is now being formulated by a Poison Prevention Committee and will be evidenced during National Poison Prevention Week which began March 17. This committee comprises representatives of the Maryland State Department of Health, the Baltimore City Health Department, the Maryland Pharmaceutical Association, the Maryland Academy of Pediatrics, the Baltimore Safety Council and the Federal Food and Drug Administration.

Marvin C. Jones Appointed to Community Counseling Clinics

Mr. Marvin C. Jones, Clinical Psychologist, has been appointed Clinical Director of Community Counseling Clinics in the Baltimore City Health Department.

Mr. Jones, a graduate of The Johns Hopkins University, received his Master of Arts degree in 1963 from Wayne State University in Detroit and his Master of Public Health degree from The Johns Hopkins School of Hygiene and Public Health in 1967. A native of Detroit, Mr. Jones served his clinical psychology internship at the Veterans Administration Hospital at Dearborn, Michigan. From 1963 to 1966 he was employed as clinical psychologist for the Baltimore City Health Department's Alcoholism Clinic, a position he left to become staff psychologist for the Supreme Bench of Baltimore.

In his new post, Mr. Jones assumes direction of the City Health Department's mental hygiene clinics in the Eastern and Southeastern Health Districts. The two clinics provide psychiatric counseling services for emotionally disturbed young children and adolescents residing within the two health districts.



Paul F. Guerin, MD, Chairman
Library and History Committee

Elizabeth Sanford
Librarian

DR. LOUIS KRAUSE, LIBRARY COMMITTEE 1952-1968

For many years the Library and History Committee has been chaired by Louis Krause, MD, a truly dedicated scholar and physician. Each year when the committee convened for its first meeting, Dr. Krause endeavored to steer the chairmanship toward another member, but the unanimous decision was that he remain in that position. So it was with regret that the group accepted his resignation in the fall of 1967.

During his many terms of office Dr. Krause fought diligently for the establishment of an adequate Rare Book and History of Medicine Room for the library. Realizing that the Library Committee and administration did not realize what a valuable collection of rare volumes and memorabilia, as well as manuscript material was included in our stacks, Dr. Krause, upon the advice of Miss Gertrude Annan, Director of the New York Academy of Medicine, became interested in securing the services of an expert consultant to survey the library's book and journal collection. Mr. Lee Ash was chosen to make this appraisal and has now been working with the staff at intervals for several months.

Dr. Krause will always be associated with his efforts in behalf of the Medical and Chirurgical Faculty of Maryland Library.

Following his resignation, the committee elected Paul F. Guerin, MD, already a member of the Library Committee, as Chairman. Dr. Guerin, a pathologist, is also active in many other Faculty efforts and we look forward to working with him as Library and History Committee Chairman.

Annual Meeting Library Exhibit

During the sessions of the 1968 annual meeting the library will have a collection of newer books on display in the Blue Room of the Alcazar. Not only will members be invited to browse through, but may also charge out any titles they wish or reserve titles not included in the exhibit.

For assurance in finding the exact subject or title you wish, it is recommended you write the library and request these materials be brought to the exhibit booth and held there for your pick-up.

Forthcoming Meetings of Interest

The next meeting of the Baltimore Hospital Librarians' Association will be held at the Loch Raven Veterans' Administration Medical Library, Loch Raven Blvd., Baltimore, March 21. Mrs. Janet Koudelka, Assistant Librarian in charge of Rare Book and History of Medicine Departments, Welch Medical Library, will be the speaker. The subject of her talk will be "Special materials in hospital libraries." All hospital librarians in the area are invited to join this group. For information, contact Mrs. Norma Gross, President, at Church Home and Hospital, Broadway and Fairmount Avenues, Baltimore, Maryland.

* * *

The regional meeting of the Medical Library Association will be held in Richmond, Va., October 4, 1968.

* * *

During the meeting of the Delaware, Maryland and District of Columbia Hospital Association, the Baltimore Hospital Librarians Association will sponsor a panel on medical libraries on December 3, 1968.

Microforms Workshop

Special Libraries Association, Baltimore Chapter, will sponsor a workshop on microforms on March 27, 1968. Place: Kennedy Room, Hotel International, Friendship International Airport, Baltimore. Hours: 9:30 to 4:30 P.M. For information contact Mrs. Ruth McCullough, Westinghouse Defense and Space Center, Box 1693, Baltimore, Maryland 21203, or telephone 765-2858.

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State of Maryland
Department of Health
WILLIAM J. PEEPLES, MD, MPH, COMMISSIONER

Record 4,000 Films Lent in 1967

Drug abuse, sex education, venereal disease, and alcoholism were the chief topics covered in 4,000 loans of health education films during 1967. This is an all-time record for requests filled, and an increase of 100 over 1966.

Other popular film subjects were traffic safety, mental health, adolescents, maternal health, and nutrition.

Health Education films are summarized in "A Guide Book Describing Pamphlets, Posters and Films," recently issued in a revised third edition and available from the Division of Health Education.

HIGHLIGHTS

Intensive Anti-Smoking Campaign Conducted

The National Smoking Test, presented by CBS television network in January, was widely publicized throughout the State by distribution of well over one million test forms through schools and other channels, by a joint effort of the Department, the Maryland Division of the American Cancer Society, the Heart Association of Maryland, and the Maryland Tuberculosis Association. Distribution was aided by the Maryland Department of Education.

In a similar cooperative effort, 38,000 posters provided by the Public Health Service were sent to physicians, dentists, public and school libraries, and many industries and non-profit organizations. The message, "100,000 doctors have quit smoking cigarettes . . . (maybe they know something you don't") was based on research data supplied by National Opinion Research Center, University of Chicago.

Measles Mop-Up Continues

As a follow-through to the mass measles campaigns of spring, 1967, an in-school vaccination program was begun last September, the goal being the immunization of 60,000 children between 5 and 9 years of age, believed to be still susceptible to measles. This protection is expected to prevent any widespread outbreak of measles among younger siblings. On a one-county-at-a-time basis, it was anticipated that by the end of March, 39,000 children would have been immunized against measles.

Ten New PKU Cases Recorded in 1967

Between June and December, 1967, six confirmed cases of phenylketonuria were recorded in the Health Department's registry, bringing the year's total to ten. All infants were hospitalized for extensive diagnostic study. Since the Guthrie Screening Program was initiated in the State, 24 cases have been confirmed.

A new Guthrie collection form (BL50) has been developed for use by private physicians and health department clinics for collecting initial specimens. Initial blood tests performed on newborns in the hospital should continue to be collected on form BL49. However, repeat or follow-up tests by hospitals should be collected on the new BL50 form. All PKU specimens should be sent to the Bureau of Laboratories, 16 East 23rd Street, Baltimore, 21218. Supplies of both forms may be obtained from the above address.

A 20-minute color film, "PKU," narrated by Dr. Emmett Holt, Professor of Pediatrics at New York University's School of Medicine, traces the medical history of the disorder and discusses its genetic aspects, with emphasis on the importance of early diagnosis and dietary management. It is available for loan from the Department's film library.

Payment Records Requested by Senate Finance Committee

Records of Medical Assistance payments to providers of service—hospitals, nursing homes, physicians, dentists, pharmacies, etc.—during fiscal year 1967 were recently furnished to Senate Finance Committee chairman Harry R. Hughes, and to House Ways and Means chairman William M. Houck, at their request.

Included with the record of physicians' payments were data explaining the figures in terms of numbers of office visits, home visits, laboratory and other services, drugs dispensed, Medicare deductibles and co-insurance paid, the numbers of recipients to whom these services had been provided, and the average cost to the State per patient per day for physicians' services. The highest amount paid to any physician for Medical Assistance patients reflected an average payment of $25.06 per patient over the year.

Report on Influenza Epidemic

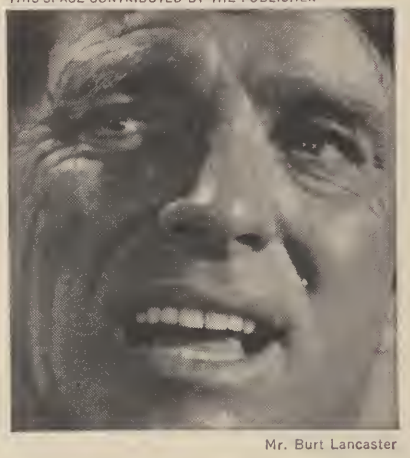
The Surgeon General's prediction of an Asian flu outbreak in the eastern states was realized in Maryland in the second week in December when a Cumberland high school reported a sudden rise in absenteeism. Three days later on December 15th the health officer of St. Mary's County reported a similar high rate of local school absenteeism from a respiratory illness. The epidemic spread rapidly throughout the State and by mid-January all counties were affected. Although influenza is not a reportable disease the school absenteeism reports showed a high attack rate among teenagers. The severity of the disease is shown by the increase in deaths from influenza and pneumonia. The weekly total reached a peak of 63 during the week ending January 25, and for the period between December 15 and February 8, 308 deaths were reported as against an expected 173. From the point of view of deaths this outbreak was not as severe as the 1962-63 epidemic. By mid-February the prevalence showed a marked decline.

Virus isolations and serologic tests made in the Bureau of Laboratories confirmed the clinical diagnosis of A2 Asian influenza in specimens taken from cases in various parts of the State.

Hearings Held on Air Pollution Regulations

The State Board of Health and Mental Hygiene on two occasions recently conducted public hearings on the proposed new air pollution regulations prepared by the Department and recommended to the Board after review by the Air Quality Control Advisory Council. Members of industry, and representatives of various interested agencies, societies, and civic groups, including the Medical and Chirurgical Faculty, were given the opportunity to present testimony pro or con. The regulations were to be presented to the Board for adoption February 23.

THIS SPACE CONTRIBUTED BY THE PUBLISHER



Mr. Burt Lancaster

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1. Unusual bleeding or discharge.
2. A lump or thickening in the breast or elsewhere.
3. A sore that does not heal.
4. Change in bowel or bladder habits.
5. Hoarseness or cough.
6. Indigestion or difficulty in swallowing.
7. Change in a wart or mole.

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Alcoholism Section

The Use of Disulfiram in the Treatment of Alcoholism

Disulfiram (Antabuse), in the proper dosage, is a safe and useful drug as an adjunct in the treatment of alcoholism. It acts by blocking the enzyme necessary for the breakdown of acetaldehyde, an intermediate by-product in the normal metabolic oxidation of alcohol.

MAXWELL N. WEISMAN, MD
Director of Alcoholism Programs and Community Psychiatric Services

Acetaldehyde accumulates in the body and may produce, after the patient swallows even as little as 15cc of alcohol, severe shocklike symptoms within 20 minutes. Flushing is experienced with severe tachycardia, palpitations, a pounding headache, rapid hyperventilation, chest pain and a sense of apprehension. After a few minutes, the blood pressure falls producing pallor and a feeling of weakness, dizziness and nausea. The patient may finally vomit and collapse completely. The reaction may last from two to four hours followed by sleep and a gradual return to normal. Severity of reaction varies with the individual and the amount of alcohol ingested.

Administration and Dosage

Before initiating therapy, *Abstinence From Alcohol for at Least 12 Hours is Necessary.* Adequate blood levels of disulfiram are not attained before at least four days of administration. Because excretion of the drug is slow, the symptoms of the alcohol-disulfiram reaction may be evoked as long as ten days after cessation of therapy.

Initial schedule is 0.5 gm (1 tablet) daily, either a.m. or h.s., for five days, followed by a maintenance regimen of 0.25 gm (½ tablet) daily thereafter.

It was originally thought advisable for each patient to have at least one supervised alcohol-drug reaction. Such a test-reaction has been largely abandoned and a clear, detailed and convincing description of the reaction is felt to be sufficient in most cases. Therapy may have to be continued on a daily basis for several months or years, depending on the individual. In certain situations, ingestion may be insured by administering the proper dosage crushed in orange juice.

The patient should be aware of the effects of the drug and take it voluntarily being warned against other medicines and foods containing alcohol. Cough medicines with less than 10% alcohol and foods containing only minute quantities such as wine-vinegar salad dressings or cooked foods in which the alcohol has been volatilized are quite safe.

Side Effects

There is an occasional skin rash (in 1% of cases) which is readily cleared by cutting the maintenance does to ¼ tablet (0.125 gm) or concomtant administration of an antihistamine. Certain individuals have noted a metallic or garlic-like aftertaste which disappears spontaneously with continuation of therapy or with the reduced dosage. Rarely is there drowsiness, in which case the

dose can be prescribed at night before bedtime. The dosage indicated above has produced no psychoses, impotence, or serious side-effects.

Contraindications

There are almost no contraindications, except as follows:

1. Unwillingness on the patient's part or without a full knowledge and understanding of the effects of simultaneous alcohol intake. It is, therefore, not wise to have someone else, such as a spouse, administer the medicine without the patient's consent and awareness.
2. During alcohol intoxication or after treatment with paraldehyde.
3. Frank psychosis or severe brain damage or mental retardation.
4. Heart failure.
5. Late stages of cirrhosis of the liver.
6. It is probably best not to give disulfiram in the early months of pregnancy though there is no evidence that it is harmful to the embryo.

Patients have been treated without ill-effects who have suffered from severe hypertension, coronary artery disease, diabetes, enlarged livers, tuberculosis, thyroid disease, and epilepsy. In such cases, however, the patients should be followed with great care.

Antidote

When reactions occur, the usual supportive measures to restore blood pressure and to treat shock should be instituted. Other suggested measures are oxygen by inhalation, carbogen (95% O_2 and 5% CO_2), intravenous doses of vitamin C (1.0 gm) ephedrine sulphate, or intravenous antihistamine. Potassium levels should be monitored, particularly when patients are on digitalis therapy since a fall in serum potassium concentration has been demonstrated during the drug-alcohol reaction. Corrective measures should be taken as required.

Comments

The disulfiram-alcohol reaction was first discovered in Denmark in 1948 and led to widespread, enthusiastic use of the drug in the treatment of alcoholism. The original suggested dose was three times that recommended at present and a number of fatalities were reported. The drug was then largely discontinued. When given, however, in the proper dose, as recommended above, disulfiram can be a most effective and safe deterrent to drinking.

It should be apparent, however, that disulfiram alone is not the complete answer as total therapy for so complex a behavior disorder as alcoholism. Its principal value lies in helping the patient maintain sobriety long enough to utilize other, perhaps deeper and more meaningful forms of therapy. It serves as an automatic brake on the impulse to drink and frees the patient from daily preoccupation with alcohol. Instead of having to make thousands of decisions each day not to drink, he makes only one—to take his medicine. The daily pill is both a symbolic and realistic commitment to total abstinence which, at the present stage of our knowledge of alcoholism, must be the goal of treatment.

A "Question and Answer" pamphlet about disulfiram for patient use is available in limited quantities from the Baltimore City Health Department Alcoholism Clinic, 2221 St. Paul Street, Baltimore, Maryland—21218.

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Rehabilitation Notes

DOUGLAS G. CARROLL, MD, EDITOR

Vocational Rehabilitation

The Economics of Vocational Rehabilitation, a book by Ronald W. Conley (Johns Hopkins Press, Baltimore 1965) has a rather formidable and unpromising title. Nevertheless, it is one of the few attempts to evaluate the importance of vocational rehabilitation in a critical and objective manner.

Conley became interested in rehabilitation because of the difficulty that his family had in obtaining education and employment for his mentally retarded sister. Because of social apathy and prejudice, she was denied a chance to prove herself.

In the early chapters, the concept and definition of disability are developed. The magnitude of the problem of chronic disease and its effect on society are evaluated. Subsequently, the program of the Office of Vocational Rehabilitation in the United States is outlined and the results are evaluated from an economic point of view. Factors influencing successful vocational rehabilitation are discussed. In the final chapter, unmet vocational needs are described, and a plea for expansion of vocational rehabilitation services is made.

An interesting and very important conclusion of this study is that the amount of dollars spent on poor-risk rehabilitation clients is as important in economic return as money spent on the better vocational prospects.

Mr. Conley states "The benefits conferred upon society as a result of the vocational rehabilitation program would ideally be measured by comparing the levels of output, the amounts of housekeeping services, and the cost of special medical, nursing and custodial care for the disabled with what such costs would have been had rehabilitation not taken place."

Unfortunately, such an evaluation was impossible once the program was put into action. It would be unethical to compare a group of patients that was given rehabilitation with a group that was not given rehabilitation. Undoubtedly many patients referred to the Office of Vocational Rehabilitation would be able to find jobs for themselves without help.

It is difficult to judge the effect of vocational rehabilitation service on the overall economy of the nation. There can be little question that the successfully rehabilitated patient benefits from the services of the Office of Vocational Rehabilitation. Finding a job and becoming a productive citizen paying taxes takes the burden of supporting the disabled person off the community. These facts, however, do not prove that reemploying disabled persons is good for the overall national economy.

"In fiscal year 1960, for example, all but 2 or 3% were placed as housewives or on jobs that would otherwise have been filled by non-handicapped workers," Mr. Conley states.

In considering the effect of vocational rehabilitation on the total economy, therefore, one must consider how many normal workers are displaced by the rehabilitant. This effect would probably be different in times of high employment than in times of low employment. It is possible, however, that for every rehabilitant placed in a job some able-bodied person is unable to get that job and may well go onto unemployment or Welfare.

"Many of the costs and gains are difficult to measure or assess, and rehabilitation sometimes increases the welfare of one part of the society at the expense of another," states the author.

Another difficulty in evaluating vocational rehabilitation are the criteria of selection of patients

who will receive the benefits. Since successful rehabilitation is the purpose of the program, there must be a tendency to accent those patients who can be returned quickly to a job with only small investments of money. This group might well be the group which would be able to get jobs without any assistance whatsoever.

Despite difficulties of making a financial evaluation of vocational rehabilitation, it is still an important task because legislatures base their appropriations on such evidence. Ideally the evaluation should be made not only in economic terms, but also in terms of human values.

Need for Expansion

Conley's conclusions about the need for expansion of vocational rehabilitation efforts has recently been documented in Maryland by a report[1] released by the Bureau of Educational Research and Field Service of the University of Maryland. This report estimates that there are 63,000 disabled persons between 16 and 65 who remain unidentified and unserved by the Maryland Division of Vocational Rehabilitation. The report emphasizes two important facts. The first is that there is a high degree of disability resulting from circulatory diseases. Secondly, there are great needs for vocational rehabilitation amongst the poor.

A second recent Maryland report[2] surveys the services for vocational rehabilitation in Maryland. Deficiencies in personnel and facilities for vocational rehabilitation are identified.

Areas of Expansion

Vocational rehabilitation in the State of Maryland needs expansion in a number of directions if it is to be fully effective. There is need for more counselors, a large modern training center for the whole State, and for more support for other conventional programs now in existence.

In addition, efforts should be made to employ patients with more severe physical and psychological disabilities than those now being worked with. Sheltered workshops, protected employment and other methods of employing marginal workers should be expanded. Methods to allow welfare recipients to risk transient employment without losing their welfare status are necessary. Efforts to improve laws to remove some of the legal barriers making employers responsible for second injuries should be continued. *The concept of disability should be widened to include age and lack of education.* This should include training not only of high school drop-outs and people over 65 but also disabled housewives and other people whose goal may not be primarily vocational.

Summary

In brief, in addition to the conventional thrust of vocational rehabilitation, there must be an extension in the concept of disability with a lessening of emphasis on vocation and an increased emphasis on persons. Such an effort will require even closer integration and use of state, local and federal, hospital, welfare, educational, industrial, legislative, homemaking and retraining facilities.

REFERENCES

1. Dishart, Martin (research coordinator): The incidence of disability in Maryland. Bureau of Educational Research and Field Services. College of Education, U. of Maryland, 1967.
2. A status report on services and facilities for vocational rehabilitation in Maryland, 1967. Governor's Study Group on Vocational Rehabilitation Comprehensive Statewide Planning Project, Balto., Md. 1967.

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THE AMA PHYSICIANS' PLACEMENT SERVICE

COMPARISON OF PHYSICIAN REGISTRATIONS AND OPENINGS IN 1966 AMA PHYSICIANS' PLACEMENT SERVICE

REGISTRATIONS				OPENINGS		
1966	1965	Grand Total	Specialty	1966	1965	Grand Total
162	130	292	General Practice	321	664	985
10	7	17	Allergy	9	12	21
47	35	82	Anesthesiology	35	29	64
27	31	58	Dermatology	15	24	39
44	29	73	ENT — EENT	34	109	143
253	226	479	Internal Medicine	221	258	479
40	43	83	Industrial	62	66	128
27	31	58	Institutional	54	76	130
11	10	21	Neuro-Surgery	8	13	21
127	137	264	Obstetrics-Gynecology	73	60	133
62	51	113	Ophthalmology	30	86	116
47	62	109	Orthopedics	41	70	111
66	41	107	Pathology	18	17	35
74	67	141	Pediatrics	115	167	282
59	40	99	Psy., Neuro. & Neuro.-Psy.	46	62	108
7	7	14	Public Health	17	9	26
59	50	109	Radiology	47	56	103
9	10	19	School Health	23	14	37
249	207	456	Surgery	97	62	159
62	53	115	Urology	27	49	76
	TOTALS	2,750*			TOTALS	3,196

*Includes 41 applications in miscellaneous categories—medical writing, plastic surgery, aerospace medicine and pharmaceutical medicine, for example.

When the rapidly approaching end of World War II loomed on the horizon in 1944, physicians on the home front foresaw the imperative need to establish an organized program to help their military counterparts return to civilian practice.

So, in December of that year, the House of Delegates of the American Medical Association established a Bureau of Information to "assist returning medical officers in their educational, licensure and placement problems."

Since the Bureau had been envisioned only as a temporary project, it was abolished in November, 1947, because it was logically assumed that its purpose—relocation of medical officers—had by then been largely accomplished. Its work was transferred to the Council on Medical Service until the "tapering off" process of service requests was completed.

But the requests never stopped. The war, directly or indirectly, had spurred profound changes. The wartime interruption of their medical practices gave medical officers an opportunity to think out their futures. It opened their eyes to new challenges and opportunities. Many physicians chose to capitalize on the chance to continue their medical education and enter specialty training.

Population patterns were changing. Some physicians took this as their cue to search for more attractive locations in which to practice. Others decided they wanted to seek out opportunities in entirely different geographic locations which held personal appeal for them. The unprecedented, uninterrupted period of post-war prosperity has served to multiply this mobility.

Consequently, the service originally performed

as a temporary expedient by the Bureau of Information not only never stopped, but has mushroomed into a major, continuing AMA service to physicians, those seeking physicians and to the nation at large.

Established as the successor unit to the Bureau in 1948, the AMA Physician's Placement Service has processed applications from 26,140 physicians seeking to be "placed," and registered 31,760 openings during its 18 years of existence. The service is provided without any charge or obligation.

Indicative of the increasingly significant role being played by PPS on a national level is the fact that it had 3,196 openings registered and 2,750 physician registrants in 1966. Back in 1948 it had a mere 200 openings and three times that number of registrants.

The AMA Physicians' Placement Service works closely with all state medical societies, about two-thirds of whom have ongoing placement programs, and with those county medical societies who have such programs. It exchanges information with them on registrant applications and practice opportunities of mutual interest.

But its dominant role and chief reason for existence lie in bringing together physicians and opportunities which are in different states or geographic areas.

Strictly speaking, the AMA Physician's Placement Service is not a "placement" service at all. Its job is to supply information to applicants and those listing openings in an attempt to match their respective needs—to help find the "right" physician for the "right" location or position. Once brought together, two interested parties then seek to work out mutually satisfactory arrangements.

As a matter of fact, PPS can not even gauge with any reasonable degree of accuracy how many physicians it has helped to "place." While it is interested in knowing the answer, the information often is not made available since a good many registrants don't report their final status. The number of "placements" is, however, believed to be substantial.

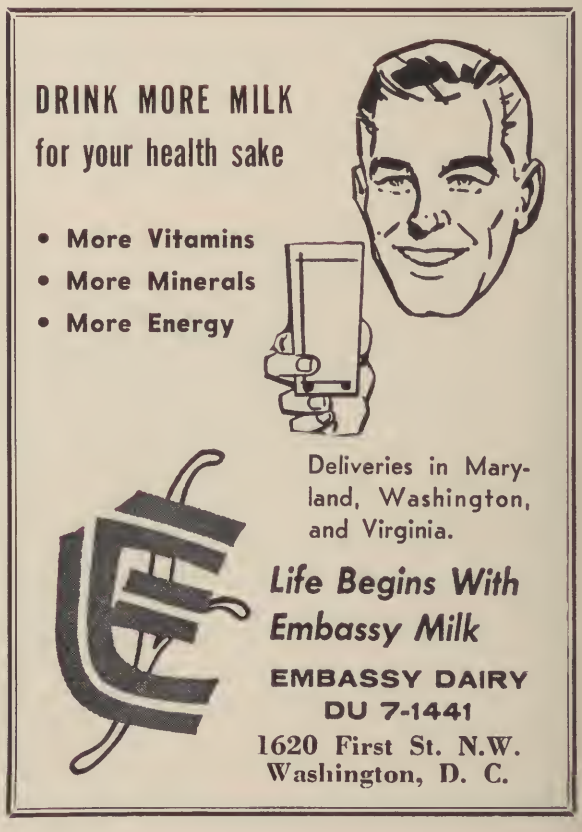
A "bonus" effect of the service is that registrants pass along the word about openings to other physicians whom they think may be interested in a particular opportunity. Placements frequently result from these word-of-mouth contacts. Even more frequently, registrants are led to other opportunities they find more attractive as the result of PPS-originated contacts.

In January, for example, a former general practitioner who had gone on to complete his residency in anesthesiology reported that he had decided to accept a position in either Indianapolis or a city in northern Michigan. Although neither position was listed with PPS, he pointed out that he had learned of both opportunities through contacts it had produced.

Many openings are filled rapidly. Some, however, take considerable time.

A physician from Minot, North Dakota, for example, searched for nearly a year and a half, traveling considerably in the process, before he found the man having the very special qualifications required to work with him in a "loose association" arrangement. Needed was a cardiologist with extensive sub-specialty training in cardiopulmonary diseases. Available were outstanding new facilities for conducting work in this area.

Precisely filling the bill was a cardiologist who had just completed his military obligation. His background included five years of the subspecialty training required.



"I never dreamed I'd wind up in North Dakota," the new associate said. "It was the furthest place from my mind, but the opportunity—the new facilities, the nature of the practice and the arrangements—met my needs perfectly."

Although PPS is but one of several sources utilized in finding physicians, some employers have experienced their best "outside" results with the program.

Said the procurement director of a well-established Wisconsin clinic with several branch offices:

> "In 1966, 14 physicians signed contracts with us. Four of these were referred by the AMA Physicians' Placement Service. Your placement service was the only one of real value. We reached all the other new associates either through classified ads or personal contacts."

The emphasis of the Physicians' Placement Service activities is on private practice—solo, partnership, group, clinic or association—but it is becoming increasingly involved in other areas, exclusive of fulltime teaching and research positions where there are few openings and which are best handled by direct personal contact or by word of mouth. In 1966, there were 215 openings listed in industrial, institutional, public health or school or college health positions.

Occasional requests are received concerning practice opportunities outside the U. S., but such openings exist almost exclusively in underdeveloped countries—Africa, Asia and Latin America, for instance. Currently, about 90 such openings, including five in Viet Nam, are listed by governmental agencies, private and denominational missionary groups and industries.

While PPS lends assistance to physicians of all ages and interests, much of its activity centers upon those seeking their first place to practice. Last year more than 300 applicants made personal visits to the AMA headquarters to discuss opportunities to practice or physician manpower needs.

"Approximately 70% of physicians registering with us are looking for their first position," pointed out Mrs. Ann Johnson, director of the service. "They're either just completing internship or residency training or completing military service.

Under a brand new program initiated by mid-year of 1967, the Physicians' Placement Service began to concentrate upon finding places to practice—full- or part-time—for physicians who had not recently been engaged in active practice. This includes older physicians who have been retired, women physicians who temporarily have abandoned medical practice and physicians who have been engaged in other areas of work.

The mechanics of the Physicians' Placement Service are relatively simple. Each applicant is asked to fill out a brief questionnaire, on which he is to list his background, education, training, personal history and references, the type of position sought and the state or geographical area preferred.

A similar form is completed by those listing opportunities to practice. This contains such pertinent information as the type of community, type of specialty training required, type of practice, any age and special requirements, financial arrangements, whether there is an opportunity for partnership, available hospital facilities, type of schools available and what type of office space is available.

Each applicant is asked whether he wants a position in his home state only, in different states in the immediate home region, in the home or a

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new region, in a new region only or has no preference. Geographic regions are divided into six categories—New England and Middle Atlantic, South, Midwest, Southwest, Mountain States or Pacific States.

Let's assume, for instance, that you are an internist in solo practice in Chicago, but would like to enter group practice in one of the Mountain States because you and your family enjoy the climate, are avid outdoor enthusiasts and feel that you would prefer a more relaxed way of life that you are likely to find in this geographic area. You desire a location in a city of 25,000-100,000 population and specify that it must have a church of your faith. You also specify what compensation you expect to receive.

In filling out your application, you find that PPS will circulate your resumé on a blind basis since you prefer to remain unidentified. Unless you have specified otherwise, a copy of your coded application will automatically be sent to each of the state medical association placement services in this geographic region.

Shortly thereafter, you will receive from PPS a list of all current openings for internists. You also will be advised that PPS will forward a copy of your coded resumé to all individuals, groups and communities having openings meeting your specifications.

PPS then will forward to you any letters from interested parties. If the position interests you, it is up to you to follow up by initiating contact. PPS has then fulfilled its role as intermediary by supplying both interested parties with information. It will, however, continue to send you descriptions of new openings until you advise that you have either accepted a position or are no longer interested in relocating.

In addition to the placement service, PPS also helps the practicing physician by providing carefully researched information serving as a guide in planning physicians' medical facilities and managing medical practice. It also provides communities with information about the Community Medical Assistance Program for rural communities, a plan carried out cooperatively by the AMA and Sears-Roebuck Foundation.

If you ever consider relocating or entering a different type of practice, are looking for a prospective partner, associate or an additional physician for your community, or are thinking about building new office facilities or modernizing present ones, you'll certainly find it advantageous to find what the AMA Physicians' Placement Service has to offer. And if you hear of someone who is "looking," you may do him a big favor by referring him to PPS.

PUBLICATIONS LIST

To obtain free copies of any of the following publications describing various services provided by the PPS, write to Physicians' Placement Service, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

FINDING A PLACE TO PRACTICE (an eight-page pamphlet describing the Physicians' Placement Service and outlining sources and factors to be considered in choosing a place to practice or relocate)

THE BUSINESS SIDE OF MEDICAL PRACTICE (a 56-page brochure containing detailed information covering the business aspects of conducting medical practice)

A PLANNING GUIDE FOR PHYSICIANS' MEDICAL FACILITIES (a 54-page brochure containing valuable guides for established physicians seeking to build or modernize medical facilities)

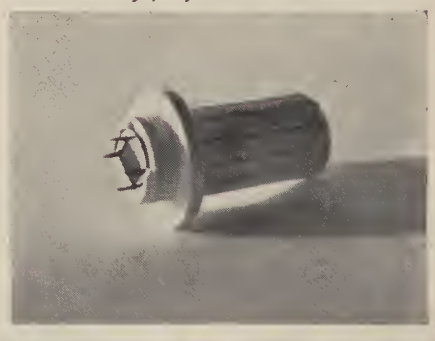
THE SEARS-ROEBUCK FOUNDATION MEDICAL CENTER (a four-page pamphlet describing architectural plans for a rural medical building and the Community Medical Assistance Program)

WHAT DO YOU KNOW ABOUT PHYSICIANS' PLACEMENT SERVICE? (a four-page pamphlet)

A DOCTOR FOR YOUR COMMUNITY (a 19-page pamphlet providing guidelines for communities to follow when undertaking to procure a physician)

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Contraindications: Glaucoma or severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in elderly males with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

(1) Bilbao, M. K.; Frische, L. H.; Rösch, J., and Dotter, C. T.: Hypotonic Duodenography, Scientific Exhibit, Radiological Society of North America, Chicago, Nov. 27—Dec. 2, 1966.

(2) Bilbao, M. K.; Frische, L. H.; Dotter, C. T., and Rösch, J.: Hypotonic Duodenography, Radiology *89:*438-443 (Sept.) 1967.

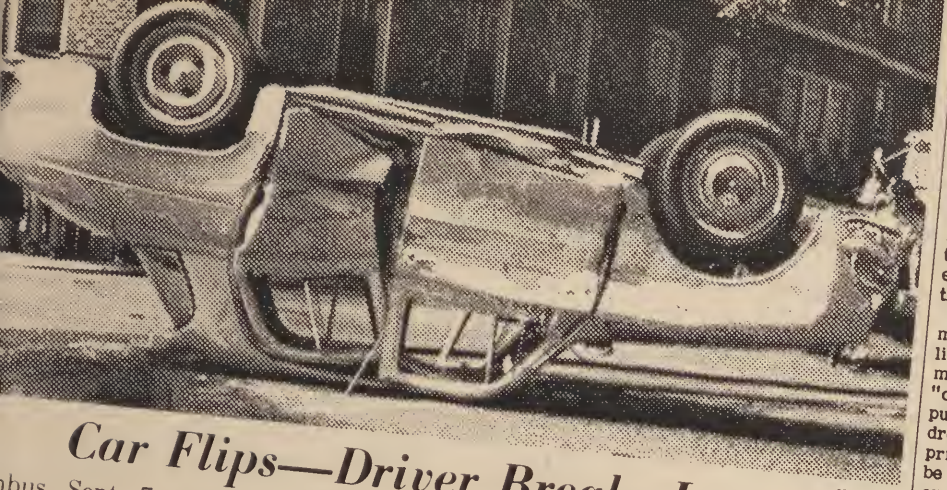
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STAFF PHOTO

Car Flips—Driver Breaks Leg

...bus, Sept. 7. John P. Jones of ... Lar... incurred a broken leg today ... driving ... Patrolman B. R. Brown, the car hit a fire hydrant and flipped over on its ... Hasn't he ... ...itar

issue, a... tember th... fications' ... ton dicta... Althou... made Mo... down by a ... ter shar... flat obje... was pass... Board ... McCred... tion" s... elimi... the st... The c... ment ca... limit ra... mile li... "cut-of... public ... dren ... priv... be b... or th... schoo... The ... so so... rathe... burs...

He's had enough excitement for one day.

For the patient who has been through an accident, the worry and anxiety following the experience may actually heighten the perception of pain. This is why there's a classic 1/4 grain *sedative* dose of phenobarbital in Phenaphen with Codeine—*to take the nervous "edge" off,* so the rest of the formula can control the pain more effectively.

Phenaphen® with Codeine

Phenaphen® with Codeine No. 2, No. 3, or No. 4 contains: *Phenobarbital* (1/4 gr.), 16.2 mg. (Warning: may be habit forming); Aspirin (2 1/2 gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, 1/4 gr. (No. 2), 1/2 gr. (No. 3), or 1 gr. (No. 4). (Warning: may be habit forming).

THE COMPOUND ANALGESIC THAT CALMS INSTEAD OF CAFFEINATES

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** 1 or 2 capsules at 2 to 4 hour intervals, or as directed by physician. For further details see product literature.

A. H. ROBINS COMPANY
RICHMOND, VA. 23220 A·H·ROBINS



LOW-BACK PAIN

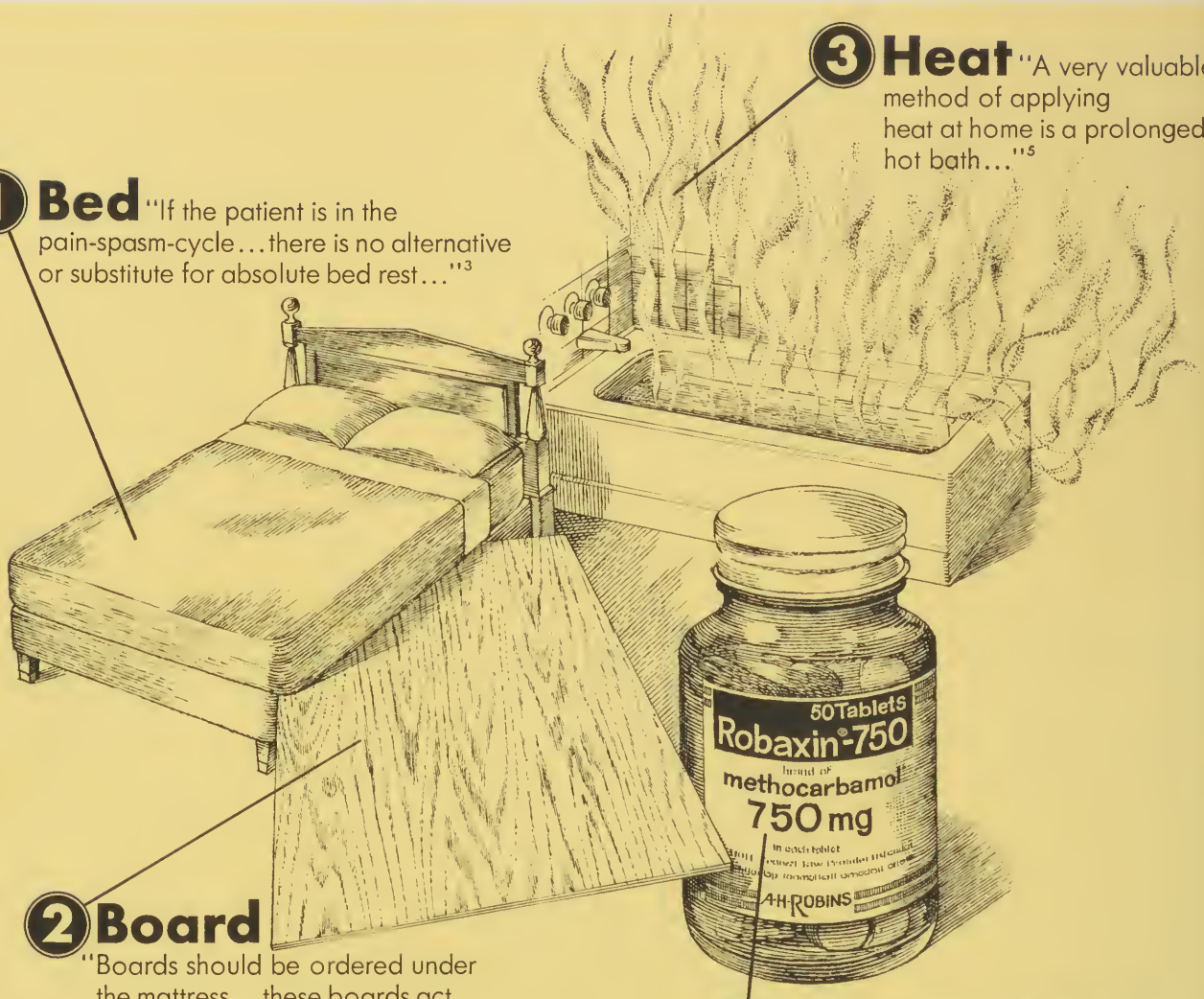
A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:

1 Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

2 Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

3 Heat "A very valuable method of applying heat at home is a prolonged hot bath..."[5]



4 Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."[7] And there is little likelihood of sedation.[6]

Indicated for relief of skeletal muscle spasm. **Contraindicated** in hypersensitive patients. **Side Effects** (lightheadedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently. See product literature for further details. **Also available:** Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.)

References: (1). Godfrey, C.M.: Applied Therap. *8*:950, 1966. (2). Gottschalk, L.A.: GP *33*:91, 1966. (3). Rowe, M.L.: J. Occup. Med. *2*:219, 1960. (4). Cozen, L.: South Dakota J. Med. *18*:26, 1965. (5). Soto-Hall, R.: Med. Sc. *14*:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

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Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done... in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
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in sinusitis, colds, U.R.I.
Dimetapp® Extentabs®
(Dimetane® [brompheniramine maleate], 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)
up to 10-12 hours clear breathing on one tablet



If hypothyroidism leaves your patient feeling like this...

consider

LETTER®

(SODIUM LEVOTHYROXINE, ARMOUR) TABLETS

Synthetic Thyroid Replacement Therapy



Letter® provides all the advantages of the synthetically pure chemical sodium levothyroxine. Dosage is precise and potency is consistently uniform.

and

Letter® is micronized to provide maximum opportunity for full absorption and clinical response.

In addition Letter® is distinctively color coded with an identifying number stamped on each tablet to provide accurate dosage control.

Indications: Hypothyroid conditions. **Contraindications:** Thyrotoxicosis, acute myocardial infarctions unless associated with hypothyroidism. In hypothyroidism with hypoadrenalism coadministration of corticoids with LETTER® is recommended. **Precautions and Side Effects:** Excessive dosage may result in diarrhea, cramps, palpitation, nervousness, rapid pulse, sweating. If symptoms appear, discontinue medication for several days, then reinstitute at a lower level. Since myxedema patients with heart disease may suffer seriously from abrupt increases in dosage, caution should be exercised in adjusting dosage. **Dosage:** Generally, the initial adult dosage is 0.1 mg. daily. This may be increased in small increments every one to three weeks until proper metabolic balance is achieved. **Available:** Bottles of 100 tablets, in six potencies: 0.025 mg. (violet), 0.05 mg. (peach), 0.1 mg. (pink), 0.2 mg. (green), 0.3 mg. (yellow), and 0.5 mg. (white).

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Woman's Auxiliary

MRS. HARRY L. BERMAN, EDITOR

NINETEENTH ANNUAL CONVENTION, WOMAN'S AUXILIARY TO THE MEDICAL AND CHIRURGICAL FACULTY

Wednesday and Thursday, April 17 and 18, 1968

HEADQUARTERS—SHERATON-BELVEDERE HOTEL
Charles and Chase Streets, Baltimore, Maryland

Preliminary Program

WEDNESDAY, APRIL 17, 1968
RED ROOM, Second Floor

MRS. WILLIAM S. STONE, *President*
Presiding

P.M.

2:00 Registration—
Mrs. Joseph B. Workman,
Chairman

2:30 PRECONVENTION BOARD MEETING
Business Meeting

8:30 THEATER PARTY
Benefit of AMA-ERF
Morris Mechanic Theater, Baltimore
For tickets or information:
Mrs. H. Melvin Radman
Telephone: LA 3-4410
or LE 9-0872 x 17

THURSDAY, APRIL 18, 1968

AUXILIARY HOSPITALITY ROOM
Open 9:00 A.M.-6:00 P.M.

A.M.

8:30 Past President's Breakfast
MARYLAND ROOM, Second Floor

TWELFTH FLOOR

9:00 Registration
Mrs. Joseph B. Workman,
Chairman
Coffee Hour

10:00 GENERAL SESSION—ASSEMBLY ROOM
Mrs. William S. Stone, *President,*
Presiding
THEME: HEALTH CAREERS
Auxiliary Prayer and Pledge of Loyalty
Mrs. H. Leonard Warres,
President-elect
Greetings from the Medical and Chirurgical Faculty—
Robert B. Goldstein, MD, *Chairman,*
Public Relations Committee which is the Advisor to the Auxiliary
Response—Mrs. Raymond M. Yow,
First Vice-President

Presentation of the Convention Chairmen,
Mrs. William J. Dunseath and
Mrs. Henry P. Laughlin
Roll Call of Delegates—
Mrs. Roy K. Skipton, *Recording Secretary*
Convention Rules of Order—
Mrs. E. Roderick Shipley, *Parliamentarian*
Credentials
Mrs. Karl F. Mech
Minutes of the 1967 Semiannual Meeting
Mrs. Wallace H. Sadowsky,
Reading Committee Chairman
Report of Treasurer—
Mrs. S. G. Sullivan
Presentation of Budget—
Mrs. M. McKendree Boyer, *Finance Chairman*
Introduction of Honored Guests
Mrs. William S. Stone, *President*

Presentation of the Presidents of the Component Auxiliaries — Reports will be distributed in printed form

Presentation of Auxiliary Officers and Chairmen —Reports will be distributed in printed form

Special Reports

Mrs. Robert J. Rosensteel, Jr., *President,* WASAMA, The University of Maryland School of Medicine

Miss Pat Myskowski, *President,* Future Nurses and Health Careers Club of Maryland

Report of the President
Mrs. William S. Stone

Necrology—Mrs. Vincent O. Eareckson

Courtesy Resolutions
Mrs. Martin E. Strobel

Report of Nominating Committee
Mrs. Percy H. Sutley, *Chairman*

Election of officers—Installation of Officers

MRS. AMOS N. JOHNSON, *Director, Woman's Auxiliary to the American Medical Association*

Presentation of Gavel
Mrs. William S. Stone

Inaugural Address
Mrs. H. Leonard Warres

11:30 A.M.-12:30 P.M.
SHERRY HOUR
Ballroom, Twelfth Floor

Mrs. Richard D. Bauer, *Hospitality Chairman*

12:30 P.M.
LUNCHEON, BALLROOM

Reservations for tickets ($3.75 each, including gratuity) must be in the hands of the *Chairman,* Mrs. S. G. Sullivan, 419 Oak Lane, Baltimore, Md. 21204, by April 12, 1968. Reservations are limited. Doctors are invited.

Invocation—DONALD CRAIG KERR, ThD
Roland Park Presbyterian Church, Baltimore, Maryland

Presentation of Honored Guests—
MRS. WILLIAM S. STONE, *President*

Greetings from the President of the Medical and Chirurgical Faculty
RICHARD D. BAUER, MD

Guest Speaker—MRS. AMOS N. JOHNSON, Garland, North Carolina
Director, Woman's Auxiliary to the American Medical Association

MRS. ROBERT J. DAWSON, Cumberland, Md., *Chairman,* Health Careers Committee, Woman's Auxiliary to the Allegany County Medical Society

"IN OUR OWN BACK YARD"

Presentation of Awards
MRS. H. MELVIN RADMAN, *Chairman* AMA-ERF

Presentation of President's Pin—
MRS. WILLIAM S. STONE, *President*

Presentation of Past President's Pin—
MRS. ARCHIE R. COHEN, *Immediate Past President*

Adjournment

POST CONVENTION BOARD MEETING

3:00 P.M.-5:00 P.M.
DIXIE ROOM, Second Floor
Mrs. H. Leonard Warres, *President* Presiding

6:15 P.M.
Ballroom, Twelfth Floor
ANNUAL RECEPTION AND PRESIDENTIAL DINNER
Medical and Chirurgical Faculty of the State of Maryland

CONVENTION COMMITTEE CHAIRMEN

Convention Co-Chairmen
Mrs. William J. Dunseath
Mrs. Henry P. Laughlin

Tickets and Reservations
Mrs. S. G. Sullivan

Hospitality
Mrs. Richard D. Bauer

Flowers and Decorations
Mrs. Ferd E. Kadan

Favors
Mrs. Elmer G. Linhardt

Registration
Mrs. Joseph B. Workman

Credentials
Mrs. Karl F. Mech

Awards
Mrs. H. Melvin Radman

Courtesy Resolutions
Mrs. Martin E. Strobel

Necrology
Mrs. Vincent O. Eareckson

Hostesses
Mrs. John G. Ball
Mrs. A. Austin Pearre, Sr.
Mrs. John O. Robben
Mrs. John R. Smith, Jr.

The AMA's Exhibits Section:

Its 111 Exhibits Play a Big Role in both Graduate Medical Education and Health Education



One of the most popular AMA exhibits is the "Transparent Twins," created primarily for a high school-level audience. The exhibit provides a concise explanation of 25 body organs, plus the skeleton and nervous system. It has been shown to more than 60 audiences.

Since 1899 the AMA has employed the eye-catching, high-impact medium of exhibits to further postgraduate medical education. But it has been only within the past 15 years, through the creation of the Bureau of Exhibits, that the AMA has expanded use of the exhibit technique to further public health education as well.

The Bureau was started by since retired Thomas Hull, PhD, an international authority on scientific exhibits and the man for whom the Hull Award, bestowed annually at the AMA's Clinical Convention, is named. Through reorganization the Bureau now is known as the AMA's Exhibits Section of the Program Services Department.

Emphasizing the extent of its operation is the fact that each year more than two-million persons visit these exhibits, presented from coast to coast at medical meetings, health fairs, state and county fairs and other health programs arranged by medical societies, auxiliaries and those in the allied professions.

In its peak year, 1966, the section booked 435 exhibits in 117 cities for the equivalent of 2,391 "show days."

Currently the section offers 111 exhibits, an all-time high. About half are aimed at the medical profession and the other half toward the general public. Their insured value is $197,000.

The complex tasks of creating, building, maintaining, scheduling and shipping the exhibits fall under the direction of Russell Cheadle, director of the Exhibits Section. Ideas for exhibits and suggested copy messages for them emanate from AMA councils, committees and departments when changing situations or emphasis suggest the need for an exhibit on a particular medical subject. Before an exhibit can be built, however, it must be approved by the AMA's Staff Committee on Printed Materials and Exhibits, which reviews the potential need, practicality and costs.

One entirely new exhibit being readied for use early this spring is, "The Drug Dependent Patient," designed for the profession. The exhibit describes four basic families of dependency inducing drugs, tells how to diagnose drug dependency and outlines treatment for it.

Developing entirely new exhibits, however, accounts for only about half the actual construction. The remainder is directed toward rebuilding damaged exhibits or redesigning those requiring updated messages.

Two such revised exhibits now being completed are "Poisoning in the Home" and "Digestion." Occasionally new exhibits can be built from the basic structure of retired exhibits. Such is the case with the new "Health Careers" exhibit which became available last fall. Currently, there are four models of this exhibit—all built from spare parts.

Naturally, it takes plenty of space to house exhibits at their permanent quarters. There are 3,500 square feet of space at the AMA's "exhibit warehouse" in Chicago. Although the AMA's exhibits are "built to travel," they nevertheless take a beating in their constant travels and period-

ically must be rehabilitated at the warehouse.

The Exhibits Section's biggest volume comes from fairs, particularly health fairs. Last year the section provided exhibits for 14 health fairs, the largest of which was the highly successful Nebraska Centennial Health Fair, sponsored by national, state and county health organizations under the direction of the Lancaster County Medical Society. The event, attracting 92,000 persons, featured more than 100 exhibits, including several which were built locally especially for the fair. Indicative of its success and the excitement it created is the fact that at one booth 2,000 potential eye-bank donors were signed.

Among other big health fairs last year were the Annual Chicagoland Health Fair, which attracted 62,000 persons and one presented at Abilene, Texas, which featured 100 exhibits, including 30 loaned by the AMA. To accommodate this large show, the AMA exhibits were shipped, "piggyback." Among the smaller health fairs was one held at the school gymnasium in Benton Harbor, Michigan. It included 40 exhibits which were viewed by 3,500 persons.

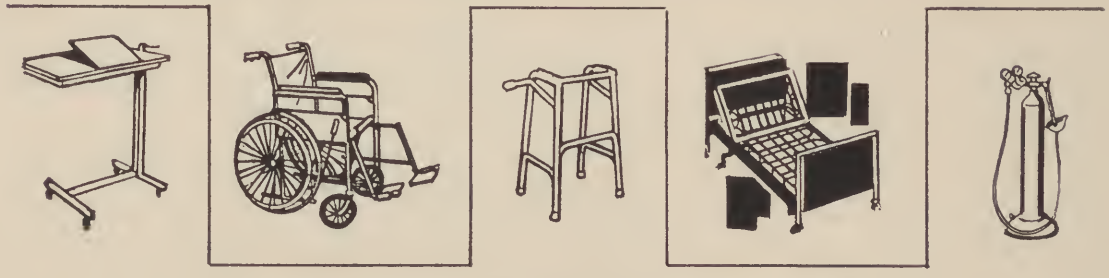
"It takes at least a year of careful planning for anyone to stage a health fair properly," Mr. Cheadle pointed out, "but you can always count on them being immensely popular. After all, a health fair is one of the few places where people can get information about themselves.

"They're also a convenient, practical way for physicians of the community to render a public service." he said. "Since time and other factors limit physicians in their public service efforts, health fairs are an ideal way to perform such a service."

To obtain AMA exhibits or investigate the possibilities, medical societies and individual physicians should direct inquiries to the Exhibits Section. A minimum of two months' written notice is encouraged to assure availability of the exhibits sought. Several months' notice is essential for health fairs or other showings requiring a large number of exhibits. Also available is essential information needed by those seeking to plan health fairs.

A complete description, including a photograph, of each AMA exhibit is contained in the exhibits' catalog maintained by each state medical society. Revised information is provided annually to state medical societies so that individual descriptions of each exhibit are current. All AMA exhibits are loaned with no charge other than shipping costs.

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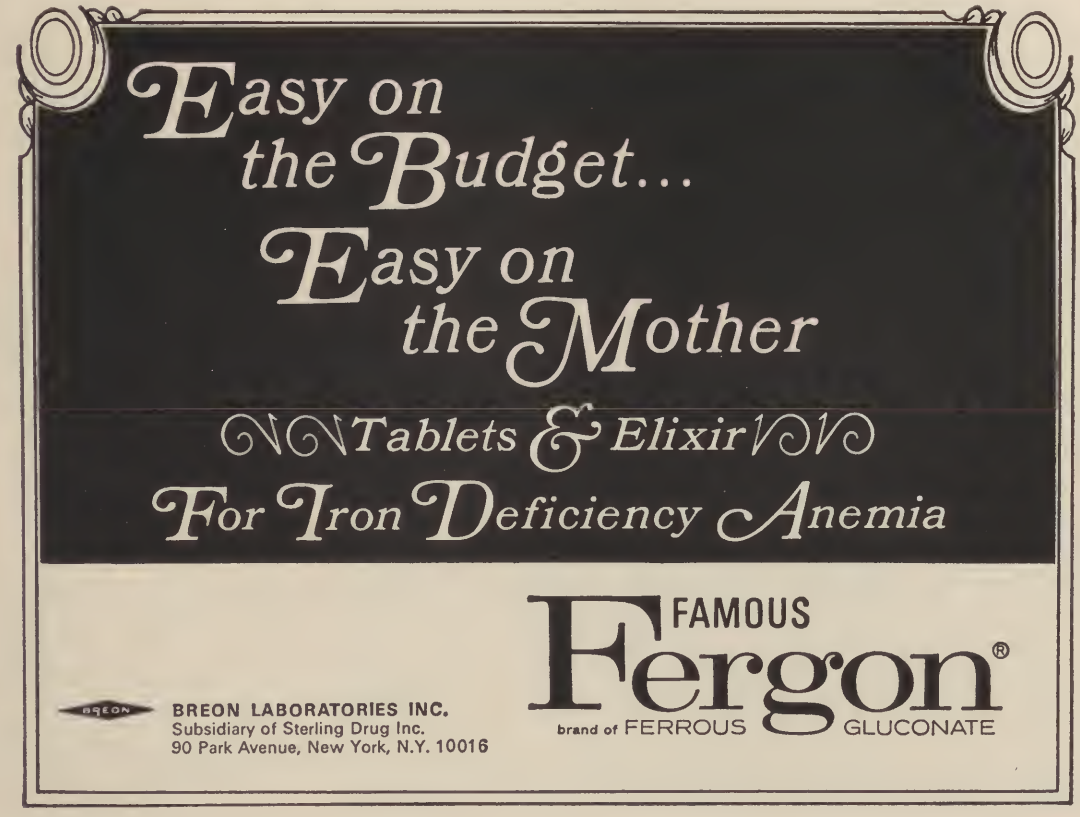
ASCO

MEDICAL ASSISTANTS' WEEK

APRIL 14-20

For the past two years the Governor has proclaimed a week to be set aside for the glorification of medical assistants in Maryland. Hopefully, this will be repeated this year. As part of the activities on the part of the Maryland Association of Medical Assistants during this week, members will volunteer their services to man the Health Evaluation Booth at the Alcazar for the Medical and Chirurgical Faculty meeting on April 17, 18 and 19, as well as run the Coffee Booth.

On Friday evening, April 19, the medical assistants are planning a variety show which will be held at the Loch Raven Elementary School, 1801 Glen Keith Boulevard, near Taylor Avenue, from 8:00-10:00 P.M. Talent for the show has been donated by professionals and semi-professionals so this should be top-grade entertainment. Acts already in rehearsal include a French Can Can chorus number by dancers from the Dorothy Virgilio School of Dance; the Grapes of Wrath, a rock and roll band; a Hawaiian Hula dance by Miss Donna Shope, of the Maryland Cabaret Theatre; Specialty Act by The Fantastiks; Barbershop Quartet numbers by the Sweet Adelines; folk singing with audience participation by That Generation; "Take Back Your Mink" by Miss Donna May Shop; Comedy act; and music by The Fabulous Monarchs, a fifteen-piece band that has recently cut two new records and is going on a Viet Nam tour with Bob Hope this summer. There will be two-hundred records given away free to the first teenagers to arrive at the auditorium. These will be donated by the Master of Ceremonies, Mr. Charles Weber who is Public Relations representative for the Kerby Scott show and who has his own recording studio. Mr. Weber



has been most kind to offer his services to help promote this show and it is hoped that there will be a tremendous audience to repay him for his efforts in our behalf. Tickets may be obtained from Mrs. Nell Chaney by calling 732-4730, ext. 453. These sell for $1.50 for adults and $.75 for children under 12.

On Saturday, April 20 the annual meeting of the M.A.M.A. will be held at the Sheraton-Belvedere Hotel. Registration will begin at 10:00 A.M. for the business meeting, which will include election of new officers. At 1:00 P.M. the afternoon seminar will be open by a welcoming address by Milton B. Kress, MD, Asst. Professor of Medicine at The Johns Hopkins University and Chief of Pulmonary Diseases at Church Home and Hospital. On the program following will be Ephraim Lisansky, MD, Associate Professor of Medicine and Psychiatry at the University of Maryland, who will speak on "Psychosomatic Medicine," and Mrs. Eleanor Nash, columnist for the Sunpapers, who will speak on "Public Relations." In the evening there will be a cocktail party and banquet at the Belvedere, when Ian Anderson, MD, of Church Home and Hospital will be Master of Ceremonies and Rev. Thomas Subock, of Annapolis, will act as Chaplain. This seminar and the festivities following are open to the general public and anyone desiring to attend should also contact Mrs. Chaney.

One of the highlights of the meeting will be welcoming the members of the Montgomery County Medical Assistants Association, a new chapter which held its first meeting on February 21 in Wheaton, Maryland. Mrs. Dorothy Hartel helped to organize this group and she and Mrs. Chaney, M.A.M.A. President, attended the meeting. Officers were installed and are listed below:

President—Sandra Orrison
Vice President—Sandra Moore
President Elect—Frances Whittaker
Secretary—Jean Klopfer
Treasurer—Margaret Eid

There was much enthusiasm for their new enterprise and we expect much from this group. Beldon Reap, MD, of the Medical Examiner's Office, Montgomery County, was present as Advisor to this chapter and gave a welcoming address at the meeting. Also on their Board of Advisors are: Donald Bucy, MD, Steven Conway, MD, Thomas Johnson, MD, and Mr. John Loy. Congratulations on a most successful meeting to the MCMAA!



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Take a relaxing break for Coca-Cola. Couple of times a day. Because Coke has the taste you never get tired of. It's always refreshing.



One by one the family's downed Because the G.I. bug's around

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric*
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin,
and protects intestinal mucosa

Whether it's a 24-hour "bug", a food problem, or simply nervousness and anxiety, Parepectolin will bring the diarrhea under control until etiology can be determined. In some cases, Parepectolin may be all the therapy necessary.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) ..... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified) .... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.
Usual Children's Dose: One or two teaspoonfuls three times daily.

ROER

WILLIAM H. RORER, INC.
Fort Washington, Pa.

Medicare Deadline: April 1st

Over one million older people in the country are receiving letters this week, reminding them that they have only until April 1 to sign up for the voluntary doctor bill insurance under medicare.

In the letter, Robert M. Ball, Commissioner of Social Security, points out that nearly 18 million people—92% of those over 65—have already signed up for the doctor bill insurance to supplement their basic hospital insurance under medicare. Since the program started only 18 months ago, he notes, it has helped pay over 28 million medical bills, totaling almost $1.3 billion.

About 1.6 million people 65 and over missed out on their first chance to elect the supplementary medical insurance, according to Commissioner Ball. The Social Security Administration is sending letters to the 1.1 million for whom it has addresses—those who have been issued medicare cards showing that they are covered only by the basic hospital insurance part of medicare.

The Social Security Administration does not have current addresses for the other 500,000 older Americans because they have never applied for even the hospital insurance under medicare.

Just about everyone now over 65 is eligible for the voluntary part of medicare—whether or not they have ever worked under social security, and whether retired or still working. He urged persons 65 and over and not signed up for medicare's doctor bill insurance to get in touch with their social security district office if they do not get a letter in a week or so.

In his letter, Commissioner Ball lists 8 reasons

• Photo-Offset Printing • Letterpress Printing
• Multigraphing • Monocast Letters
• Multilithing • Mimeographing
• Addressing & Mailing • Typing
• Automatically Typewritten Letters

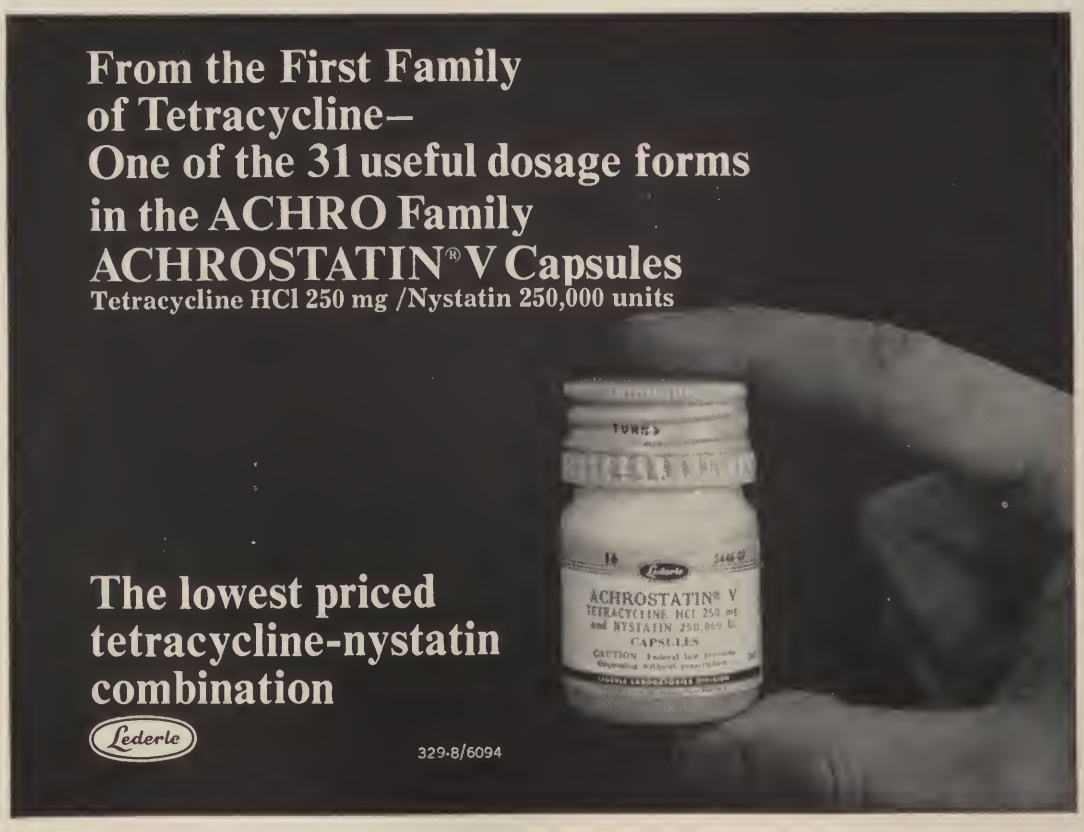
Prompt Pick-up and Delivery **MU 5-3232**

D. Stuart Webb
Advertising Services, Inc.
306 N. Gay Street Baltimore, Md. 21202

that older people without the supplementary doctor bill insurance ought to consider. He also encloses a leaflet explaining the medical insurance benefits and an enrollment card to be sent back showing whether or not the person wants the protection.

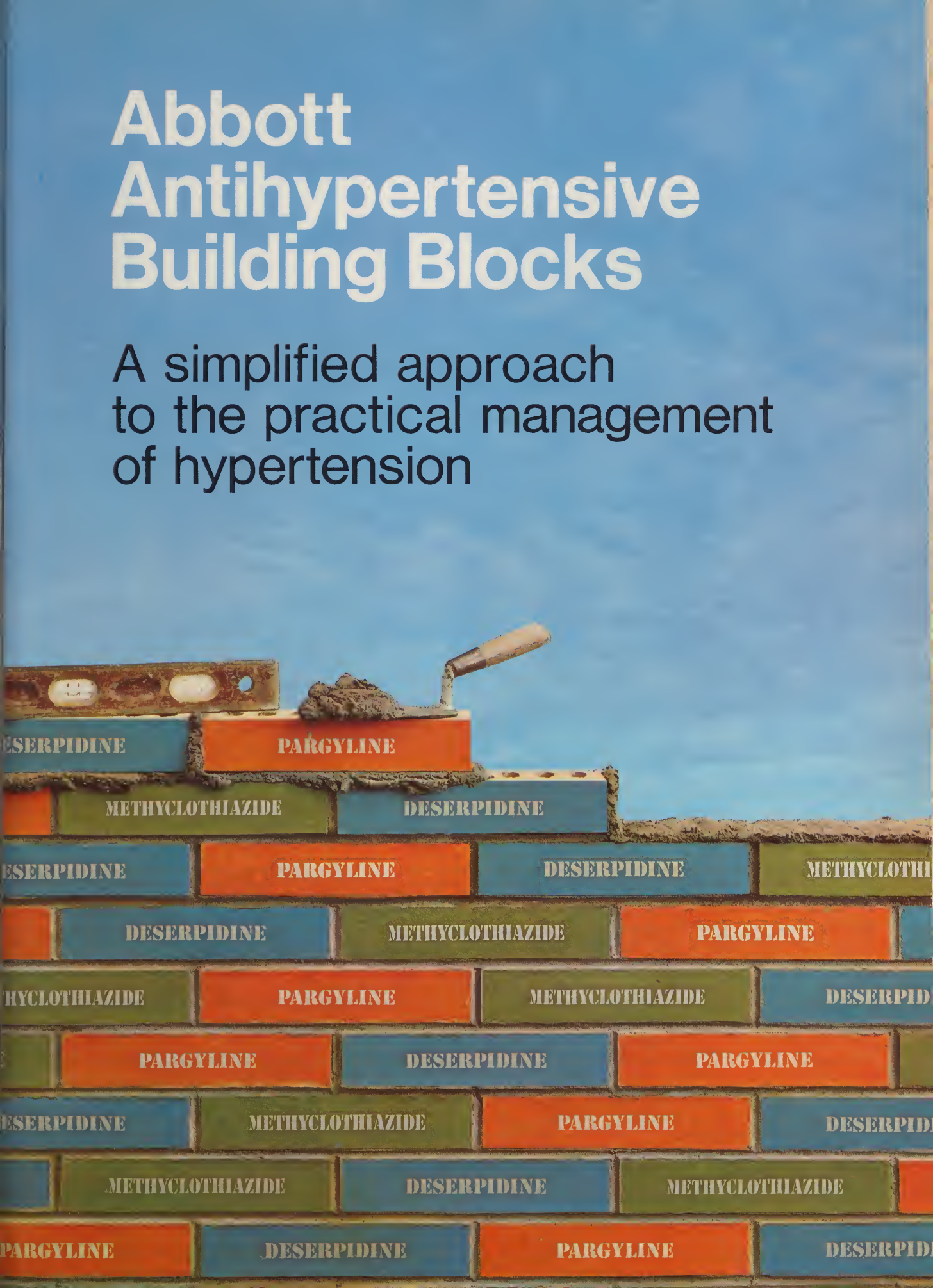
As reasons for signing up now, the Commissioner cites:

- That the $4 premium rate represents an excellent buy because it represents only half the cost of the protection. The Government pays the other half.
- It may not be possible to obtain the basic coverage any other way. For the most part, Blue Cross-Blue Shield and the commercial insurance companies have rewritten their policies for people 65 and over to supplement medicare.
- The 1967 changes in the law make it easier to collect medical insurance benefits.
- There are a number of improvements in medical insurance benefits, for example, the payment of the full reasonable charges for X-ray or laboratory services furnished to a bed-patient in a hospital and coverage of physical therapy services at home or elsewhere.
- The increase of 13% in social security benefits, recently enacted by Congress will in most cases be more than enough to cover a social security beneficiary's half of the premium—and to increase his monthly check.
- Beginning in April, covered outpatient hospital benefits will be paid only under the medical insurance part of medicare. To have outpatient hospital coverage, therefore, the older person must be signed up for the medical insurance program.
- The protection will cost more later on. The premium is 10% higher for each year that has passed since the older person's first opportunity to enroll.
- People over 65 and still not signed up for the supplementary medical insurance by April 1, cannot get the protection until July 1, 1969. A delay of more than 3 years after the person's first opportunity to enroll means that he will not be able to get the protection at all.



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Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persits for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

ENDURON®

METHYCLOTHIAZIDE

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

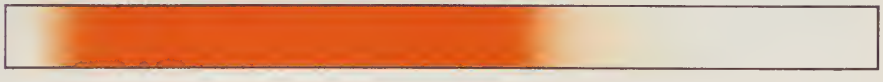
Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

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METHYCLOTHIAZIDE 5 mg. with DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

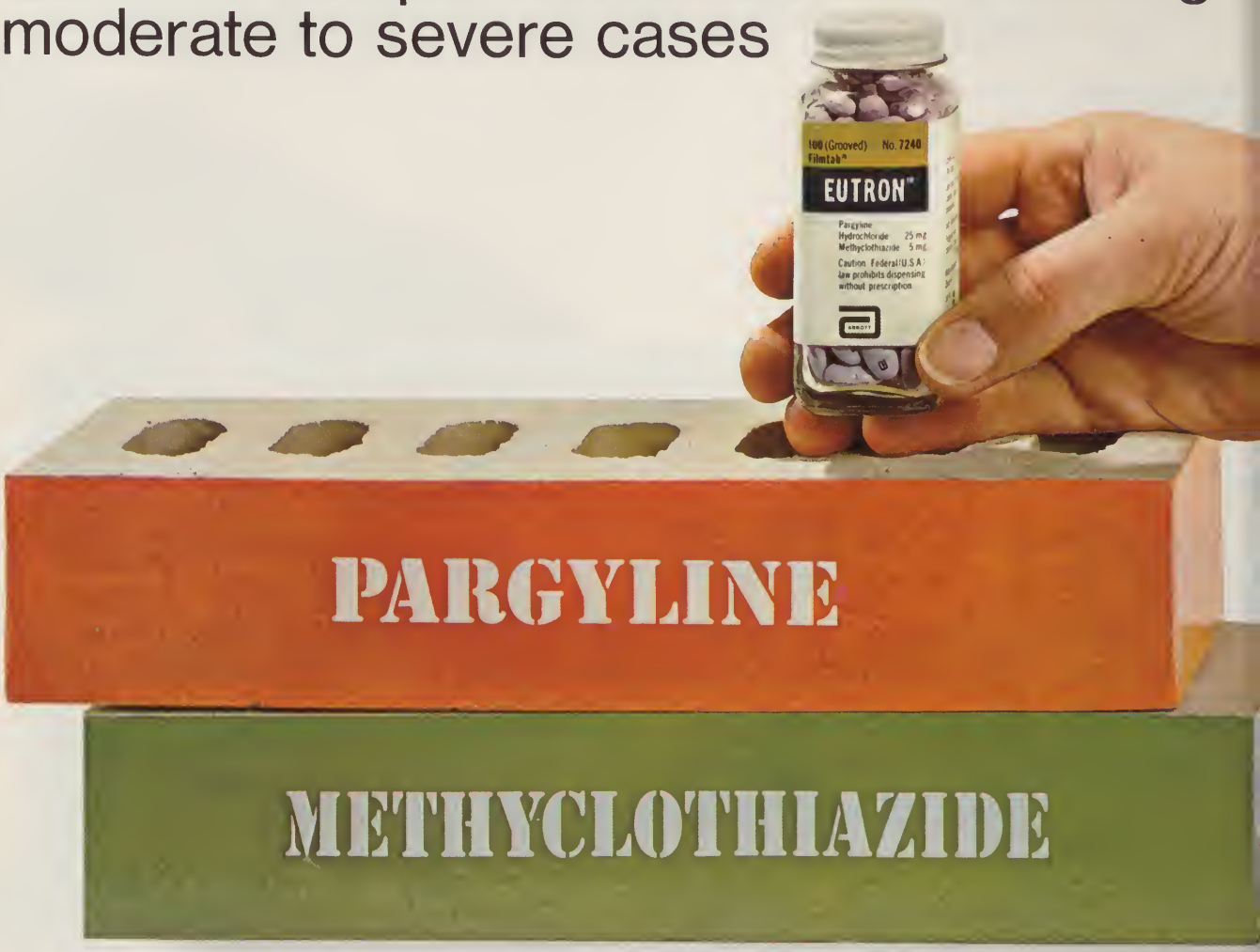
MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

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Eutron: A unique combination for handling moderate to severe cases



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Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

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EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

801094

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains Methyclothiazide 5 mg. with Deserpidine 0.25 mg. or 0.5 mg

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains Pargyline Hydrochloride 25 mg. with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for patients with mild or labile hypertension amendable to therapy with sedatives and/or thiazide diuretics alone. It is desirable to establish the dosage of Eutron by administering component drugs separately.

Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery ¼ to ⅕ the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.

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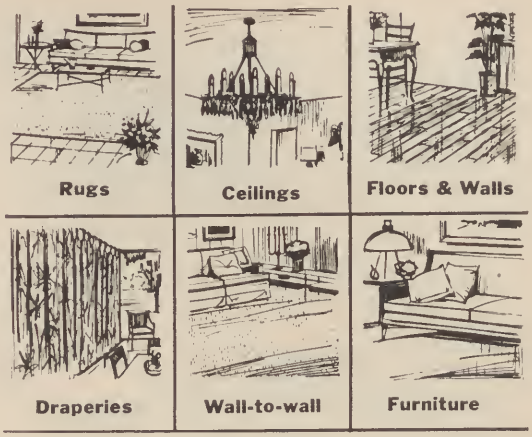
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COMPONENT MEDICAL SOCIETIES

BALTIMORE CITY MEDICAL SOCIETY

SEMIANNUAL BUSINESS MEETING
FRIDAY, APRIL 5, 1968, 8:30 P.M.

AGENDA

Call to order
Minutes of previous meeting.
Election of new members.
Moment of silence in memory of deceased members.
Review of business to be transacted at House of Delegates Meetings April 17, 1968, 9:30 A.M. and April 19, 1968, 2:00 P.M.
Other new business.

At the monthly meeting on February 13, 1968, the Board of Directors of the Baltimore City Medical Society approved the waiver of dues for Arthur Owen, MD, and Isaac Miller, MD, because of incapacitating illness; and extended leave of absence for Adalbert F. Schubart, MD, on sabbatical leave at Johannes Gutenberg University in Germany during 1968.

Mrs. Leonard H. Warres, president of the Woman's Auxiliary to the Medical and Chirurgical Faculty of Maryland, presented a plan to increase the membership of the auxiliary which entailed the additional assessment of $6 per year from Society members. The Board discussed the plan but felt it could not be recommended.

Three problem cases were examined by the Professional Relations Committee. One has since been referred to the Mediation Committee of the Faculty and the other two were judged and appropriate dispositions were recommended.

The recent changes in the by-laws of the Baltimore City Medical Society necessitates reprinting and circulating the more up-to-date material. The Board feels this is an opportune time to undertake this job since the original supply is almost depleted.

The Board discussed nominees to be recommended to the nominating committee of the Faculty for the offices of President-elect, First, Second, and Third Vice-President, Secretary, Treasurer, Councilors, Delegate to AMA, Alternate

Delegate, Program and Arrangement Committee, Library Committee, Finney Fund Committee, and the Board of Medical Examiners. The selection was made and the names submitted to the nominating committee.

The problem of filling the vacancies in the Baltimore City Medical Society's list of Delegates was referred to Harry Connolly, MD, chairman of the Nominating Committee.

Letters written to the Editor of the Sunpapers from Israel Zeligman, MD, and Harry Robinson, MD, were read and the attitude was heartily supported by the Board of Directors.

Also read was a letter from John Collins Harvey, MD, confirming the appointment of Frank F. Furstenberg, MD, to the Nursing Home Subcommittee; and a letter from Governor Agnew in regard to the establishment of a Special AD HOC Committee to be chaired by Russell A. Nelson, MD.

Arthur E. Cocco, MD
Journal Representative

MARYLAND EAR, NOSE AND THROAT SOCIETY

Tuesday, March 26, 1968 Dinner 6:30 P.M. Speaker 8:00 P.M.

Speaker: Glassell S. Fitz-Hugh, MD, Professor Otolaryngology, University of Virginia School of Medicine.

Subject: Laryngeal and Cervical-Tracheal Injuries

Place: Kennedy-Warren Hotel, 3133 Connecticut Avenue NW, Washington, D.C. Irving L. Ochs, MD, *President*, Samuel M. Lumpkin, MD, *Secretary*

MARYLAND OPHTHALMOLOGICAL SOCIETY

Thursday, April 4, 1968 Cocktails 6:00 P.M. Dinner 7:00 P.M. Speaker 8:00 P.M.

Speaker: Samuel D. McPherson, Jr., MD, Durham, North Carolina

Subject: Microsurgical Techniques of Cataract Extraction

Place: Statler-Hilton Hotel, 101 W. Fayette Street, Baltimore

William E. Newby, MD, *President*, Irvin P. Pollack, MD, *Secretary*

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MARYLAND ORTHOPAEDIC SOCIETY

Monday, April 8, 1968

The Four Cities Orthopaedic Group Meeting in Washington, D. C. George N. Austin, MD, *President*, Elroy Young, MD, *Secretary*

MARYLAND PSYCHIATRIC SOCIETY

Thursday, April 11, 1968 8:30 P.M.

Moderator: G. Wilson Shaffer, PhD, Professor of Psychology, Director of Psychiatric Clinic, The Johns Hopkins University

Subject: College Drop-Outs

Discussants: Ghislaine Godenne, MD, Richard Doss, MD

Francis McLaughlin, MD, *President*, Eugene Brody, MD, *Secretary*

PATHOLOGY SECTION

Monday, April 15, 1968 8:00 P.M.

Speaker: Edward L. Sherrer, Jr., MD

Subject: Determination of Blood Gases (illustrated)

William J. Hicken, MD, *Chairman*, James E. Taylor, Jr., MD, *Secretary*

ANESTHESIA STUDY COMMITTEE

Tuesday, April 23, 1968 7:30 P.M.

Joint Anesthesia Study Committee of the Baltimore City Medical Society and the Baltimore City Health Department.

CARROLL COUNTY MEDICAL SOCIETY

At its January meeting the society elected the following officers to serve during 1968: Karl M. Green, MD, President; William R. O'Rourke, MD, President Elect; Dean Griffin, MD, Secretary; John S. Harshey, MD, Treasurer; and Mrs. Nancy B. Jones, Executive Secretary.

Also presented during the meeting was a panel discussion entitled "The Pill and the Single Girl." Participating panelists included the chairman, Gertrude Gross, MD, representing the psychiatric point of view; Charles Mawhinney, Jr., MD, OB-Gyn.; William O'Rourke, MD, Family Practice; The Rev. Mr. Harold Helfrich, Minister; Mrs. Dolores Snyder, BS, MA, Director of Pupil

Services with the Carroll County Board of Education.

The panelists underscored the importance of conducting sex education on the family level, in schools, and in the doctor's office.

* * *

Community Service projects in which the society was active during 1967 were the Mass Measle Immunization Program with the co-sponsorship of the Westminster Jaycees; and the Medical Vocations Explorer Post of the Boy Scouts of America. Various members of the society have been active on boards of the various national foundations such as the TB, and the Heart Association.

Projects for 1968 will include the establishment and development of a historical exhibit depicting the rural physician of 50 to 100 years ago. The exhibit will be in one of the historical buildings in Carroll County. Needed in particular are furnishings characteristic of a doctor's office of that period. Persons interested in donating or loaning furnishings and equipment to this permanent exhibit should contact Martin Gross, MD, 334 E. Main St., Westminster, Md., Telephone: 848-8445.

Philip W. Mercer, MD
Journal Correspondent

BALTIMORE COUNTY MEDICAL SOCIETY

On February 3, 1968, the Baltimore County Medical Society and the Hospital Staff of St. Joseph's Hospital held a joint meeting. Frank Faraino, MD, of the Staff of the Hospital, arranged and presented the following scientific program:

The Biological Basis of Tissue Transplantation was discussed by Norman D. Anderson, MD, Assistant Professor of Medicine, The Johns Hopkins Medical School. Ervin A. Gombos, MD, Chief Nephrology Division, Veteran's Administration Hospital, Washington, D.C., presented a talk on **Chronic Hemodialysis. Transplantation of the Kidney** was the subject of the talk given by George Schreiner, MD, Professor of Medicine, Georgetown University Medical School. Presented by John J. White, MD, Assistant Professor of Surgery, The Johns Hopkins Medical School, was a lecture on **Clinical Experience with Kidney and Lung Transplantation.**

Following the scientific program, a business meeting was held. Gordon Grau, MD, chairman

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of the Board of Governors, gave a synopsis of the Board Meeting held on January 17, 1968.

The following action was approved by the Society: The Baltimore County Medical Society will continue its membership in the Baltimore Area Health and Welfare Council; it was decided to present a Past President's Plaque to the widow of Lewis Dalmau, MD; and honorary membership was granted to F. A. Holden, MD, and Harry Butler, MD.

The Legislative Committee held a dinner with the Baltimore County Delegation in Annapolis on February 1, to discuss matters of health.

Melvin Davis, MD, read a resolution regarding keeping the Medical Examiner's Office separate from the Health Department. This was unanimously approved and will be submitted to the House of Delegates of the Medical and Chirurgical Faculty in April.

The Medical Society will hold a dinner dance on Sunday, March 31, 1968, 6:30 P.M., at the Tail of the Fox in Timonium. Herbert J. Levickas, MD, is chairman.

Samuel N. Bacon
Chairman, Public Relations





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*Clinically cured included patients with complete symptomatic relief and those who had partial symptomatic relief within 72 hours with subsequent clinical cure.

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Indications For mixed infections which are more susceptible to the combination than to either agent alone. These may include susceptible gram-positive and/or gram-negative mixed infections. Not recommended in the treatment of infections expected to respond to full therapeutic doses of the antibiotic or sulfonamide alone.

Contraindications Known hypersensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, in premature or in newborn infants during first week of life.

Warnings As with other forms of sulfonamide therapy, use only after critical appraisal in patients with liver or kidney damage, urinary obstruction, or blood dyscrasias. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests when used intermittently or for long periods.

Precautions, Side Effects Use sulfonamides with caution in patients with a history of allergy, including asthma. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent; if encountered appropriate countermeasures (e.g. epinephrine, steroids, etc.) should be administered and the drug withdrawn. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. In prolonged therapy, or when high dosage is used, maintain an alkaline urine. If oliguria occurs, discontinue therapy. Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin; generally improved by reduction of dosage.

If overgrowth of nonsusceptible organism occurs, withdraw the drug and institute appropriate treatment.

Adverse Reactions Sulfonamide therapy may be associated with headache, nausea, vomiting, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, urticaria, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

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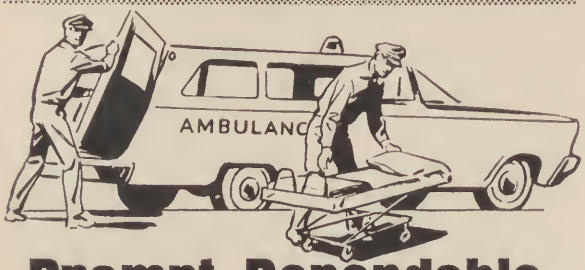
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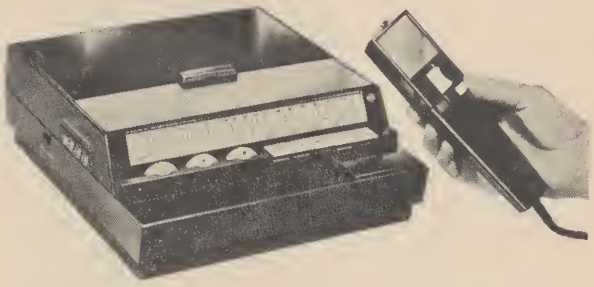
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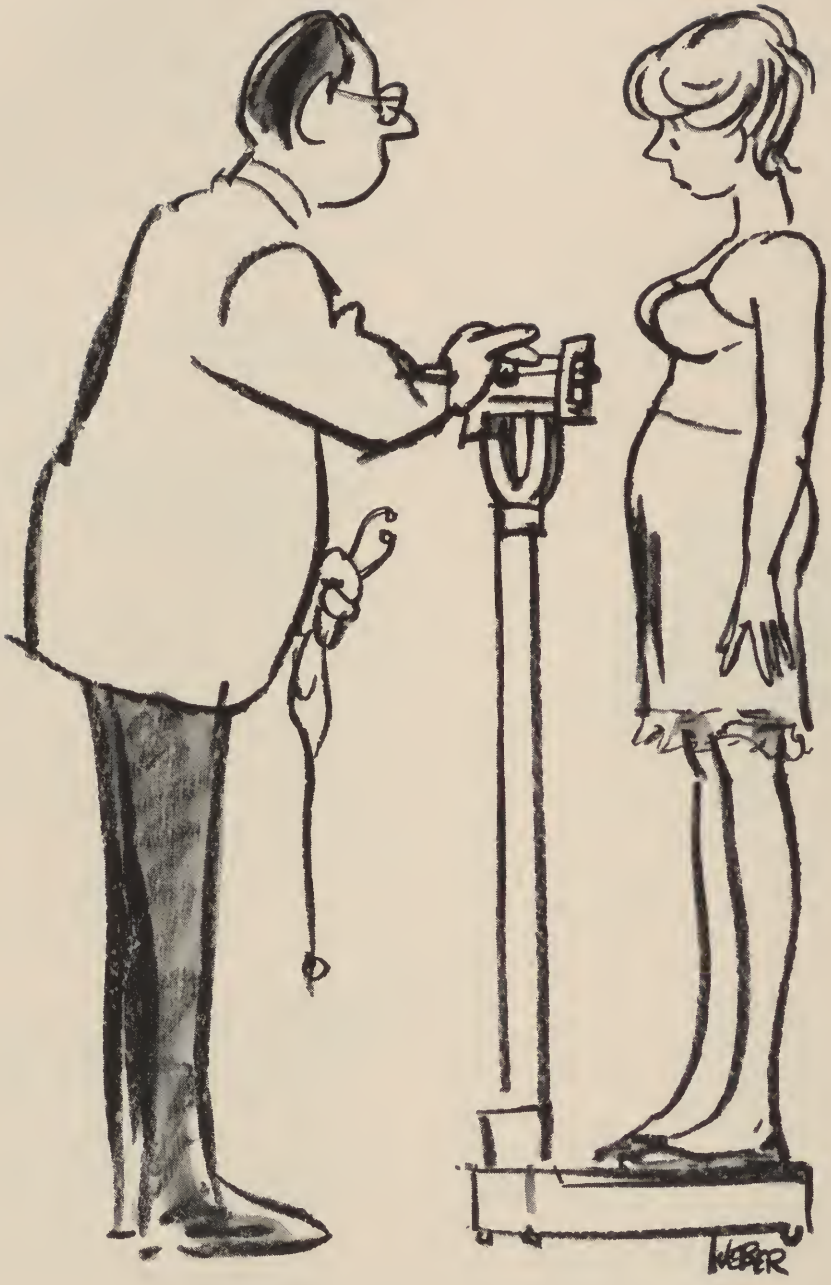
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Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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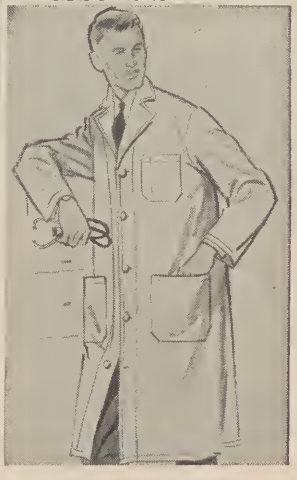
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Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of Tofrānil and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before Tofrānil may be substituted. Initial Tofrānil dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, Tofrānil should not be used during the first trimester of pregnancy.
Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment with Tofrānil. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy.
Because of its anticholinergic effect, caution should be observed in prescribing Tofrānil for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when Tofrānil was added to the regimen.
Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 years of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (includ-

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Although toxic reactions severe enough to require discontinuation of Tofrānil are uncommon, in patients with cardiovascular disease, thyroid disorders, increased intraocular pressure, or in those receiving anticholinergics (including antiparkinsonism agents), the special precautions listed in the Prescribing Information should be carefully observed. The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated.

Tofrānil® imipramine hydrochloride
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ing hypomanic and manic episodes) which may require dosage reduction and/or addition of a tranquilizer or temporary discontinuation of the drug, epileptiform seizures, orthostatic hypotension and substantial blood pressure fall in hypertensive patients, purpura, transient jaundice, bone marrow depression including agranulocytosis, sensitization and skin rash including photosensitization, eosinophilia, and mild withdrawal symptoms on sudden discontinuation after prolonged treatment with high doses. Occasional hormonal effects (impotence, decreased libido, and estrogenic effects) may be observed. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those using anticholinergic agents (including antiparkinsonism drugs).
Outpatient Adult Dosage: Initially, 75 mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Tofrānil: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
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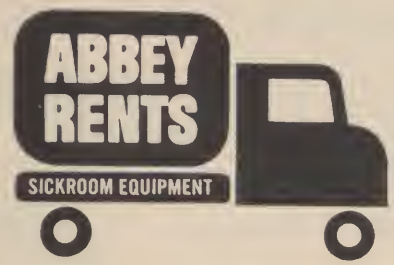
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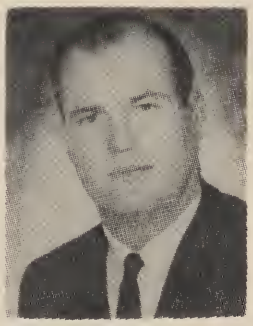
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1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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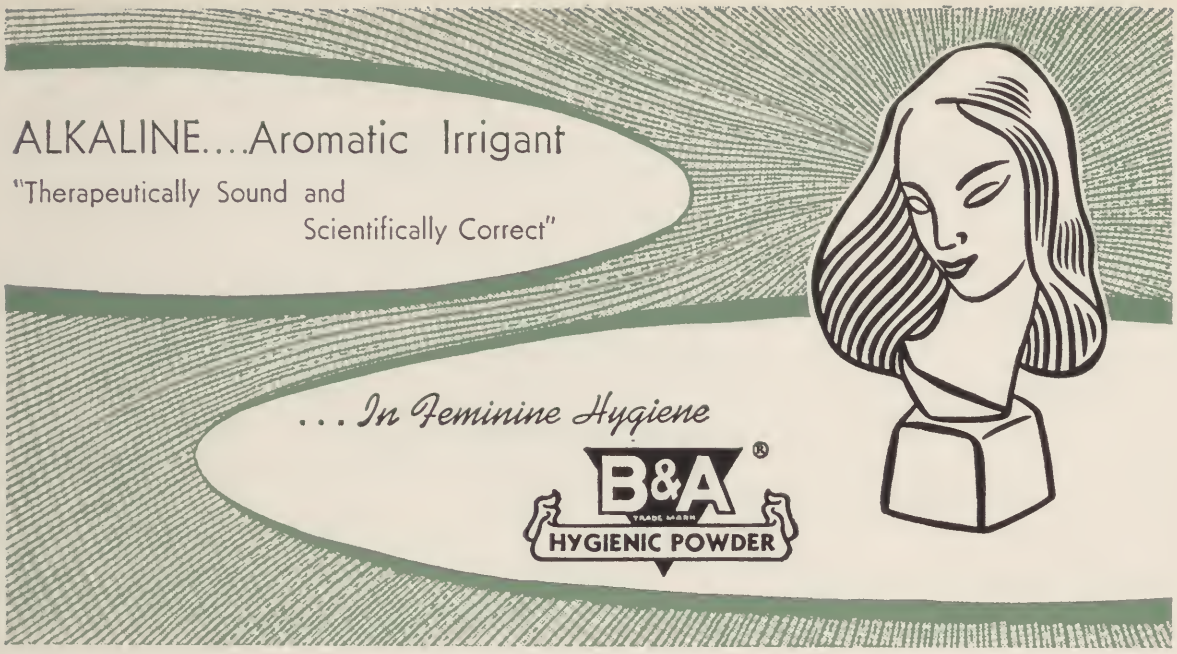
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"Early in 1953 Davis and Grand undertook a review of well established practices connected with the treatment of T. vaginalis infections. For instance, it had been accepted that an acid douche should be employed. This was based on cultural studies showing that when the pH was below 5 the organisms would die. They found that the commonly used vinegar douche with a pH of 3 showed no visible effect on T. vaginalis under the microscope in 15 minutes. Both citric and lactic acid were tested with similar results. Davis then recalled that in his early treatment of T. Vaginalis infections over 30 years ago he had had his first successes with alkaline preparations, and when he returned to their use the patients reported them more soothing than the previously used acid solutions."

(Am. J. Obst. & Gynec., 68:559, 1954)

Criteria for Cleansing Douche

"Daily douching often is a part of the treatment administered in dealing with T. vaginalis and since it is possible that the solution might contain agents that could hamper the regrowth of Doederlein bacillus, the following properties were said to be ideal.

1. It should contain a harmless, nonsensitizing detergent to remove mucous deposits and debris.
2. It should not contain any antibacterial agents, since the contact possible during douching would be so fleeting that anti-bacterial action could not be expected.
3. It should be acid in pH.

The 3rd property seems to be the most illogical and unimportant. If contact is so fleeting that antibacterial actions could not be expected, it would seem to follow that its acid quality would be of no consequence. Furthermore, acid solutions are irritating to the mucosa and oftentimes accentuate inflammation.

Actually, the value of a douche is generally conceded to be confined to its use as a cleansing and deodorizing agent. The encouraging results achieved with a detergent douche solution in treating infections of the vagina are probably attributable to the enormous normal recuperative powers of the vaginal tissues which have been under-estimated as a factor in the restoration of normal physiology.

Therefore, simple cleansing of the vagina with a non-irritating, mildly alkaline douche which is soothing to the vaginal mucosa and which penetrates and flushes out the dead organisms, debris and mucinous materials frequently enables the physiological processes to overcome the infection."

Charles B. Marek, M.D., Chief of Gynecology; Bon Secours Hospital: personal communications August 11, 1964

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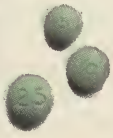
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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver-function tests advisable during protracted therapy.

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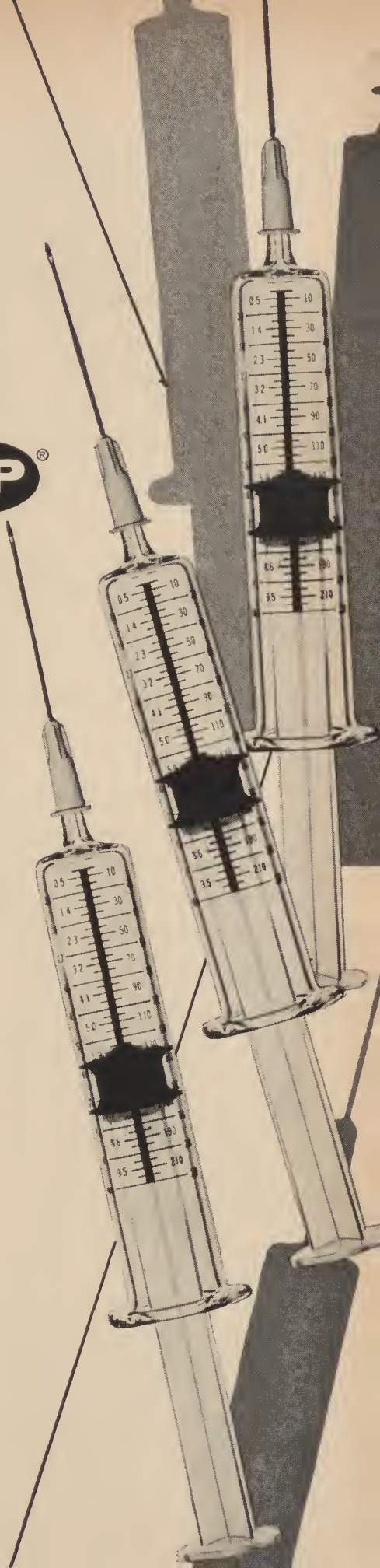


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Precautions—Overgrowth of nonsusceptible organisms may occure. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth— dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm. given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

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MID-ATLANTIC STATES SECTION AIR POLLUTION CONTROL ASSOCIATION
Semi-Annual Technical Conference—The Legal Road to Clearer Air: Gold Ballroom, Hotel Dupont, 11th St. at Market, Wilmington, Del. Contact: Reuben Wasser, Treasurer, Middle Atlantic States Section, APCA, Public Service Electric and Gas Co., 200 Boyden Ave., Maplewood, N. J. 07040.

MAY 1-3, 1968
NEW YORK UNIVERSITY, DEPARTMENTS OF DERMATOLOGY AND MICROBIOLOGY
Symposium—Virologic Approaches to Cutaneous Diseases: New York University School of Medicine, 550 First Ave., New York City. Chairmen: Rudolf L. Baer, MD, Milton R. Salton, MD. Contact: Office of the Recorder, New York University Post-Graduate Medical School, 550 First Ave., New York, N. Y. 10016.

MAY 2-4, 1968
AMERICAN COLLEGE OF CLINICAL PHARMACOLOGY AND CHEMOTHERAPY
Fifth Annual Meeting: Claridge Hotel, Atlantic City, N. J. Contact: Sage Rosen, Administrative Secretary, The American College of Clinical Pharmacology and Chemotherapy, 230 N. Broad St., Philadelphia, Pa. 19102.

MAY 2-4, 1968
MOUND PARK HOSPITAL FOUNDATION, INC.
Postgraduate Course—Gastric Psychiatry: Teaching Auditorium, Mound Park Hospital, St. Petersburg, Fla. Contact: Gastric Psychiatry, Mound Park Hospital Foundation, Inc., 701 Sixth St. South, St. Petersburg, Fla. 33701.

MAY 6, 1968
AMERICAN CANCER SOCIETY, MARYLAND DIVISION, AND BON SECOURS HOSPITAL
Cancer Seminar: 9 A.M. to 4 P.M., Bon Secours Hospital, Baltimore, Md.

MAY 12-15, 1968
AMERICAN COLLEGE OF PHYSICIANS
Postgraduate Course—Frontiers of Gastroenterology; Bellevue Stratford Hotel, Philadelphia, Pa. Co-Directors: Henry J. Tumen, MD, FACP, and James L. A. Roth, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

MAY 18-20, 1968
MEDICAL SOCIETY OF NEW JERSEY
Annual Meeting: Haddon Hall, Atlantic City, N. J. For Advance Program Contact: Jerome G. Kaufman, MD, Chairman, Committee on Annual Meeting, the Medical Society of New Jersey, 315 West State St., Trenton, N. J. 08605.

MAY 19-20, 1968
TEXAS HEART ASSOCIATION *et al*
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The complete scientific program, plus forms for advance registration and hotel accommodations, will be featured in JAMA, May 6, 1968.

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(For more convention information see page 49.)

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FRIDAY PROGRAMS

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Cor Pulmonale

Donald H. Dembo, MD, Chief of Cardiology, Maryland General Hospital

Sponsor: Maryland General Hospital

MAY 10—12:30 P.M.

Poisonous Bites

Emily Seydel, MD, Poison Control Center, Baltimore City Hospitals

Sponsor: Baltimore City Hospitals

MAY 17—12:30 P.M.

Oral Therapy in Diabetes

Abraham A. Silver, MD, Chief of Medicine and Metabolism, North Charles General Hospital

Sponsor: North Charles General Hospital

MAY 24—1:00 P.M.

Arteriosclerosis

Benjamin M. Baker, Jr., MD, Professor of Medicine, The Johns Hopkins University School of Medicine

Sponsor: Frederick Memorial Hospital

CONTINUING PROGRAMS

(Heard at participating hospitals only)

TUESDAY MORNINGS—11:30 A.M.

MEDICAL GRAND ROUNDS
University of Maryland Hospital

FRIDAY AFTERNOON—2:00 P.M.

NEUROLOGY GRAND ROUNDS
University of Maryland Hospital

SATURDAY MORNINGS—8:00 A.M.

PEDIATRIC GRAND ROUNDS
The Johns Hopkins Hospital

SATURDAY MORNINGS—10:00 A.M.

MEDICAL GRAND ROUNDS
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Kent General, Dover, Delaware
Kent & Queen Anne's, Chestertown
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Physician's Memorial, La Plata
Prince George's General, Cheverly
Provident, Baltimore
Rosewood State Hospital, Owings Mills
Sacred Heart, Cumberland
St. Joseph, Baltimore
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Sinai, Baltimore
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Harford County Health Department, Bel Air
Medical and Chirurgical Faculty, Baltimore
State Office Building, Baltimore
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The American Medical Association and the Association of American Medical Colleges announced a joint policy statement calling for a substantial increase in the number of medical students.

Milford O. Rouse, MD, president of the AMA and John Parks, MD, president of the AAMC, reviewed the joint statement at a news conference in Washington.

The statement "emphasized the urgent and critical need for more physicians if national expectations for health services are to be realized." The statement said:

"National policy which would best meet this need, and would be consistent with the American ideal of equal educational opportunity for all, would provide such educational resources that every young person interested in and qualified for entry to the study of medicine would have this opportunity. Both Associations endorsed the position that all medical schools should now accept as a goal the expansion of their collective enrollments to a level that permits all qualified applicants to be admitted. As a nation, we should address the task of realizing this policy goal with a sense of great urgency.

"In their endorsement of and call for broadening educational opportunity for the study of medicine, both Associations stressed that the length of time necessary to realize such a goal does not minimize the need to respond to today's critical shortage of physician manpower. In order to enable the nation's medical schools both to meet today's crisis and to attain the longer-range goal of unrestricted educational opportunity, those responsible for allocation of resources must recognize the magnitude of these tasks."

The two associations said both immediate and long-rang steps should be taken.

The immediate steps are:

1. To increase the enrollment of existing medical schools.
2. To foster curricular innovations and other changes in the educational programs which could shorten the time required for a medical education and minimize the costs.
3. To meet the need for innovation in educational programs and to encourage diversity in the character and objectives of medical schools. The development of schools of quality where a primary mission is the preparation of able physicians for clinical practice as economically and rapidly as possible is to be encouraged. . . .

"A longer-range approach to the need for physicians is the development of new medical schools," the statement said. "This approach will not solve our immediate, urgent need for more physicians but it is essential for meeting the national needs of 1980 and beyond."

The two associations said the longer-range program would require adequate financial support from governmental and various private sources for:

1. Construction of facilities to expand enrollment of existing schools and to create new schools.

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2. Support of the operational costs of medical schools.
3. Stimulation and incentive for educational innovation and improvement.

"To implement these measures will further require that each medical school and its university re-examine its objectives, its educational program, and its resources to determine how it can contribute mose effectively to the national need for more physicians and what financial help it will need to make this contribution," the statement said. "Also required is understanding by the public, the private foundations, industry, local and state governments, and the national Congress—groups which must provide the financial support which is necessary.

"Initiative for development of new schools and expansion of the established institutions should be locally determined. Only the governing bodies of schools with ongoing programs in medical education can decide to expand such programs. Institutions wishing to organize new medical schools must assume the responsibility for marshalling the necessary support. Both associations are prepared to lend any assistance they can to such efforts."

* * * *

In a health message to Congress, President Johnson proposed control of prices of drugs bought for government programs and asked for authority for the Food and Drug Administration to publish a drug compendium financed by drug manufacturers. He also asked for more money for health manpower and the maternity and child health programs.

With an objective of lowering costs, he also asked for authority for the Health, Education and Welfare Department to establish new formulas for reimbursement of hospitals and physicians under medicare, medicaid and maternal and child health programs. The Social Security Administration immediately announced that it would begin "an experimental program to find methods of reimbursing hospitals and doctors that will have built-in incentives to efficiency and economy."

Participation in such experiments would be entirely voluntary, the SSA said. And Congress would have to approve the necessary legislation before new methods of reimbursement could be put in effect on a mandatory basis.

Under medicare, a physician now is reimbursed on the basis of his usual and customary fee if it is considered reasonable.

HEW said two methods of reimbursement involving physicians that might be tried are:

—Group practice prepayment plans which offer comprehensive health services to their members could be reimbursed on a set per capita rate for the ensuing period.

—For physicians' services, experimental bases of payment might be a single fee related to total illness services rather than individual fees for each individual visit and individual service, agreed-upon fees held stable for specified periods, fees related to physician-time, or retainer or per capita payments per year for services of a specified kind.

Commenting on Mr. Johnson's health message, Dr. Rouse said, "There is great need for expanded health care service in the United States. Meeting this need requires devoting attention to all the elements involved in the supply of resources and manpower, the distribution of health care, and costs.

"The AMA supports private and governmental programs that help those who need help. Health care for all the people should be expanded in an orderly way so resources and needs are



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increased together and at comparable rates of growth.

"Government can and should support the construction and renovation of hospitals and extended care facilities, and together with the states and private sources, should promote a rapid increase in medical manpower.

"As for drug prices, we believe that every patient should be able to buy high quality prescription drugs at the lowest possible price. The way to accomplish this is to promote more effective price competition at the retail level, which will result in lower prescription drug prices for everyone. This should be the thrust of government programs—not price fixing for one group. Everyone should be encouraged to be more price conscious in buying prescription drugs. The physician should include both medical and price considerations in writing prescriptions and the patient should patronize that pharmacy that can furnish dependable service and the prescribed product at the lowest possible price. . . .

"The President's message contains little essentially new. It concentrates again on pouring additional millions of dollars into a health care system that is already facing requirements well beyond what it can now meet.

"Government expenditures for health care should be moderated during this period of acute shortage to control rapidly rising cost. Government can be most helpful by controlling inflation and by providing tax deductions and credits for people purchasing health insurance. . . .

"The physicians of this country will welcome a genuine partnership in health, where the Federal government will sincerely and continually seek the advice and active collaboration of those whose special services lie in medical education and the planning and provision of superior quality medical care for all citizens."

* * * *

The Board of Medicine of the National Academy of Sciences stated that the transplantation of human hearts still is in the experimental stage and proposed three guidelines for the procedure.

The Board said human cardiac transplantation should only be carried out in institutions in which these three criteria can be met:

1. The transplant teams should be highly skilled and have had extensive laboratory experience.
2. The work should be carefully planned, and the results should be rapidly communicated to others in the field.
3. Both the teams and the patients should be protected by "rigid safeguards."

* * * *

A check is being made to determine how many alien physicians, dentists and "allied specialists" are now subject to draft laws. A new law for the first time makes aliens in the medical and dental professions subject to draft up to age of 35.

* * * *

President Johnson asked Congress for $571.7 million more for medicaid for the 1968 fiscal year ending July 1, 1968.

The administration said the initial appropriation proved inadequate because of a complete lack of data and experience as to costs of such a program and a larger increase than expected in costs of hospital and other medical care.

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April, 1968

EDUCATIONAL MAIL-IN

Enthusiastic response was made by Maryland physicians to the offer of pamphlets for their patients on subjects of the physician's choice. More than 6000 postal cards have been mailed out to physicians for their distribution to their patients as needed.

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BANK CHARGE CARDS

The use of "Bank Charge Cards" by physicians for billing to their patients is considered unethical by both the AMA and the Faculty.

Telephone calls have been received at the Faculty office indicating that Faculty approval has been granted to use such services. This is incorrect.

NEWS NOTES

Hans R. Wilhelmsen, M.D., D.D.S., has been certified a Diplomate of the American Board of Plastic and Reconstructive Surgery.

George Edwards, M.D., Baltimore, spoke before the PTA of the Waverly Elementary School as part of the continuing program on eye education sponsored by the Maryland Society for the Prevention of Blindness.

AMA QUESTIONNAIRE

The March 25 issue of AMA News will include a Physician Activity Verification Questionnaire which should be completed and returned to the AMA. Your cooperation is asked in completing and returning this questionnaire.

LEGISLATIVE NEWSLETTER

The final issue of The Assemblyman, the Faculty's Legislative Newsletter, is being mailed during the next week or so. This will contain a complete rundown on activity at the General Assembly during the 1968 session.

A complete listing of bills and their fate will be included in this issue. Those persons interested in being alerted to any hearings on bills that have been referred to the Legislative Council should let the Faculty office know so that this data can be conveyed to those who wish the opportunity to be heard.

TELEPHONE CLASSIFIED BILLS

Physicians are again reporting they are receiving bills designed to give the impression they are for a classified or "yellow page" telephone listing. These originate from California and on occasion physicians have sent in checks to cover the item indicated.

This is similar to a scheme conducted throughout the state last year in which business as well as professional persons were solicited in this manner.

Charges for yellow page listings are included in the regular C & P Telephone Company monthly bills.

PERSONALITIES

David P. Mohr, M.D., has opened his office for the practice of Ophthalmology at 10 East Chase Street, Baltimore.

A. F. Abdullah, M.D., has relocated his office at 318 N. Potomac Street, Hagerstown, for the practice of Neurological Surgery.

Charles S. Rafky, M.D., has opened his office for the practice of Psychiatry at 1010 St. Paul Street, Baltimore.

John Sargeant
Executive Secretary

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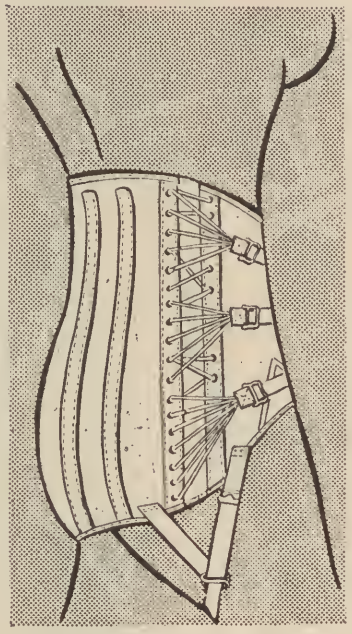
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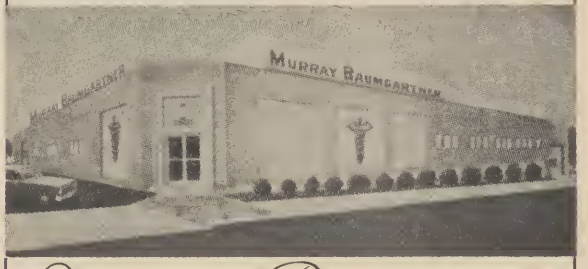
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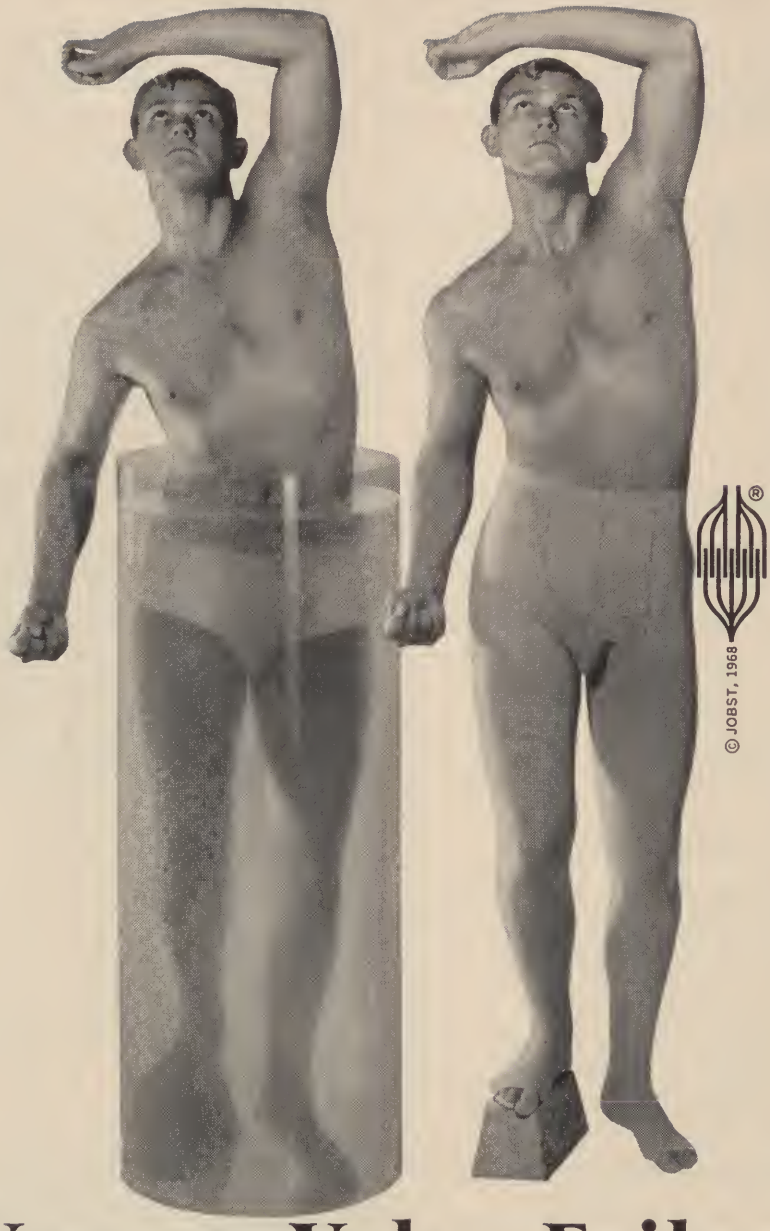
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Book Reviews

NEW DRUGS 1967 edition Evaluated by AMA Council on Drugs, American Medical Association, 525 N. Dearborn St., Chicago, Ill. 60610.

The physician must have readily available sources of balanced, authoritative information in order to cope effectively with the complexities of modern pharmacotherapy. *New Drugs*, a publication of the AMA Council on Drugs, now in its third edition, provides such information on new drugs.

The 1967 edition of *New Drugs* is a compilation of introductory statements on various therapeutic classes of drugs and monographs on single-entity drugs marketed in the United States during the period 1957-1966. It contains 265 individual drug monographs, each of which gives information on the actions and uses of the drug and its adverse reactions, contraindications or precautions, dosages and routes of administration, and sizes and strengths of available preparations. The introductory statements to 21 chapters have been throughly revised and 10 new monographs have been added. These monographs and introductory statements are based on a thorough review and evaluation by the Council of Drugs and its consultants of all of the laboratory and clinical information, including unpublished data, available to them. Thus, the book presents a concise, unbiased assessment of the newer drugs within the perspective of the therapeutic application of all of the commonly used agents in a particular class of drugs. Since a monograph on a drug is included whether or not the Council's opinion is favorable, *New Drugs* is in no sense a list of approved or accepted drugs.

The index lists drugs by both their nonproprietary (generic) and trade names and includes therapeutic entries. A list of Canadian trade names equivalents is given in the appendix.

DRUGS OF CHOICE, 1968-69; Walter Modell, MD; The C V Mosby Company, Saint Louis, Mo.

This new edition of a practical guide to the selection of the best drug for a particular therapeutic problem has a distinguished list of contributors.

Recent legal and quasi-legal actions of the FDA have created new and special problems and responsibilities for the practitioner and these are discussed in detail in the introduction.

This aspect alone warrants the purchase of this book by the practitioner who will find great assistance from it being at his elbow for consultation.

PRINCIPLES OF NUCLEAR MEDICINE, Henry N. Wagner, MD; W. B. Saunders Company, Philadelphia, Pa.

This book has an impressive list of outstanding and knowledgeable contributors listed in it. This, no doubt, adds to the quality of the material presented.

Throughout the book an attempt has been made to present the techniques of nuclear medicine in light of the diagnostic problem at hand. Since the breadth of the field makes it difficult for one person to be knowledgeable in all areas, opinions and assistance was sought from the contributors.

This book will serve as a text for the student and as a reference for the specialist; it can be used for fundamental as well as advanced training in the clinical and research applications of radioactive tracers.

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Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified)....(85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Children's Dose: One or two teaspoonfuls three times daily.

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Don't let monilia cut broad-spectrum therapy short...

start with Tetrex-F®

tetracycline phosphate complex-nystatin

Use of broad-spectrum antibiotics can cause fungal overgrowth in the alimentary tract... and give rise to symptoms so troublesome that therapy must be prematurely stopped. Tetrex-F (tetracycline phosphate complex-nystatin) helps you circumvent this problem.

The nystatin can prevent overgrowth of monilia; the phosphate complex delivers tetracycline to the blood rapidly. Side effects are infrequent.

High-Risk Patients

Tetrex-F (tetracycline phosphate complex-nystatin) is especially useful in patients most susceptible to fungal overgrowth during tetracycline therapy: (1) the elderly or debilitated, (2) young children, (3) the diabetic, (4) those on long-term tetracycline therapy, (5) those on steroid therapy, (6) those who have had moniliasis before, and (7) pregnant patients with a history of monilial vaginitis.

When you start with economical Tetrex-F (tetracycline phosphate complex-nystatin), you can complete the full course of broad-spectrum therapy with less chance of losing control elsewhere. A good start for a healthy finish.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

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The AMA'S Convention Services Department:

Its Staff of "Hotel Circuit" Veterans Strives to Bring You Maximum Comfort and Productivity at Medical Meetings

Whether you're an official program participant or a registrant seeking to capitalize on what the medical program has to offer, you expect all to be in "shipshape" condition when you attend the American Medical Association's Annual or Clinical Convention or any of more than 100 other major meetings it sponsors annually.

Quietly but efficiently working behind the scenes is the AMA's Convention Services Department, a staff of four seasoned "hotel circuit" veterans. Thanks to their savvy, long-range planning, and continuing reviews, you are assured of obtaining the best possible accommodations and most desirable arrangements for your meetings and at the most favorable rates. Also, you don't have to be harried with working out the tedious and often expensive details which confront most visitors operating independently in a strange city during a peak period.

Through the efforts of the staff myriad details are carefully coordinated to achieve a precise, orderly operation in the scientific and industrial exhibit area, the scientific sessions, House of Delegates meetings and other official convention meetings, plus the most effective housing procedure for all concerned.

Right now, for instance, you may be on the verge of deciding whether to attend the AMA's 117th Annual Convention, June 16-20, in exciting San Francisco.

But to members of the Convention Services Department staff that Convention, to a large degree, is now history. They've been working out the intricate planning details since the 1964 Annual Convention in San Francisco closed.

"Few events can tie up a city worse than a huge convention like the AMA presents," points out Wayne Burmeister, department director. "It's especially difficult in an extremely popular tourist city like San Francisco where space always is at a premium. That's why we started so soon in working out details for the 1968 convention."

Despite the early start, however, and excellent cooperation from the Housing Bureau there, there is still a shortage of space. Since negotiations began, one contracted hotel has closed and another has gone "residential."

Consequently, only 8,200 rooms have been committed—1,800 less than the 10,000 used in 1964—creating a space problem which defies a practical solution. In obtaining those rooms hundreds of hotels were inspected by the staff, but only 120 met the required standards. Housing at these approved facilities is handled through the San Francisco Housing Bureau on a "first-come, first-served" basis. An additional 3,500 new hotel rooms are expected to be available there during the 1972 AMA Convention. Everyone looks forward to this reduced housing pressure.

Since the AMA's Annual Conventions attract up to 70,000 registrants, they are the most time-consuming meetings for which to plan, but working out arrangements is less complicated since only the four present sites—San Francisco, New York, Chicago and Atlantic City—have ample, centrally located exhibit and hotel space, plus



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other desired services and features needed to handle them.

With other meetings it is a different story. The Board of Trustees already has scheduled Annual and Clinical Convention sites through 1974. Competition among cities wishing to vie as sites for future meetings is becoming increasingly keen. By 1975 at least a half-dozen more cities will have ample facilities to host the Clinical Convention.

In 1967 the department set up 164 future ancillary meetings and handled an additional 137 held that year. This involved working up complete housing, meeting, catering and other essential arrangements for more than 10,300 people—exclusive of the Annual and Clinical Convention totals.

In keeping pace with this hectic activity, members of the department naturally have become experts in the field. Members of the staff travel extensively (about 25% of their time) to conduct their on-site inspections, to study new or proposed hotel and exhibit hall developments and to establish contracts and agreements. It requires constant checking and rechecking because situations and circumstances can change rapidly. A hotel that was noted for its top service a couple of years ago may be the town's "lemon" today—or tomorrow. In meeting its obligation to physicians the staff must know hotels from coast to coast like a book.

Its members strive to see that you have no problems when you arrive at your Convention or meeting location so that you and your guests have a pleasant, comfortable stay while enabling you to further your medical knowledge.

Because of its advance planning, Conventions and meetings run smoothly and whatever you need is on hand, or can be obtained readily. As many as 150 part-time employees are hired locally to provide these services, some of which are required on a 24-hour basis. From AMA headquarters alone, 175 or more employees are on location to help staff the conventions and take care of the more than 300,000 pounds of freight shipped to meet required service or programming needs.

To further serve guests an Information Center is operated and staffed by knowledgeable people who can answer your questions. At the 1967 Annual Convention in Atlantic City, members of this staff answered more than 16,000 questions posed by registrants. That included Information Center facilities at the main center in the exhibit hall, the main floor information depot, the scientific area depot, the message center, telephone center and special stations along the Boardwalk.



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The therapeutic action is smooth, and persists for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

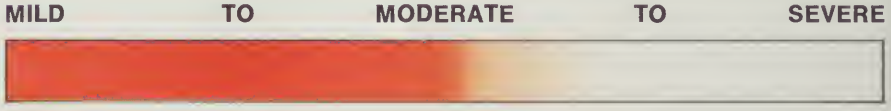
Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

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MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

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METHYCLOTHIAZIDE 5 mg. with DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

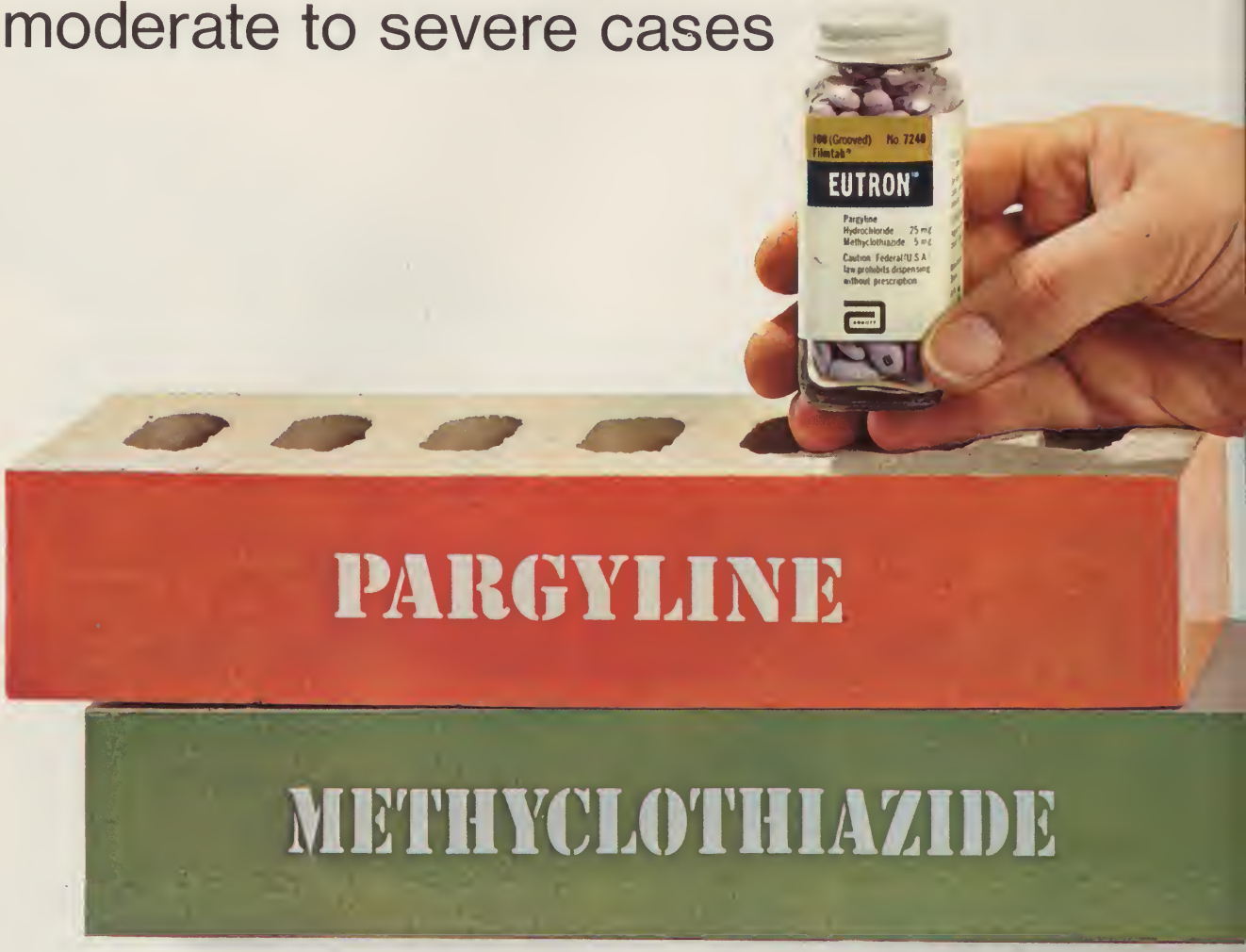
MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

801094

Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

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PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

801094

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, Impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage; caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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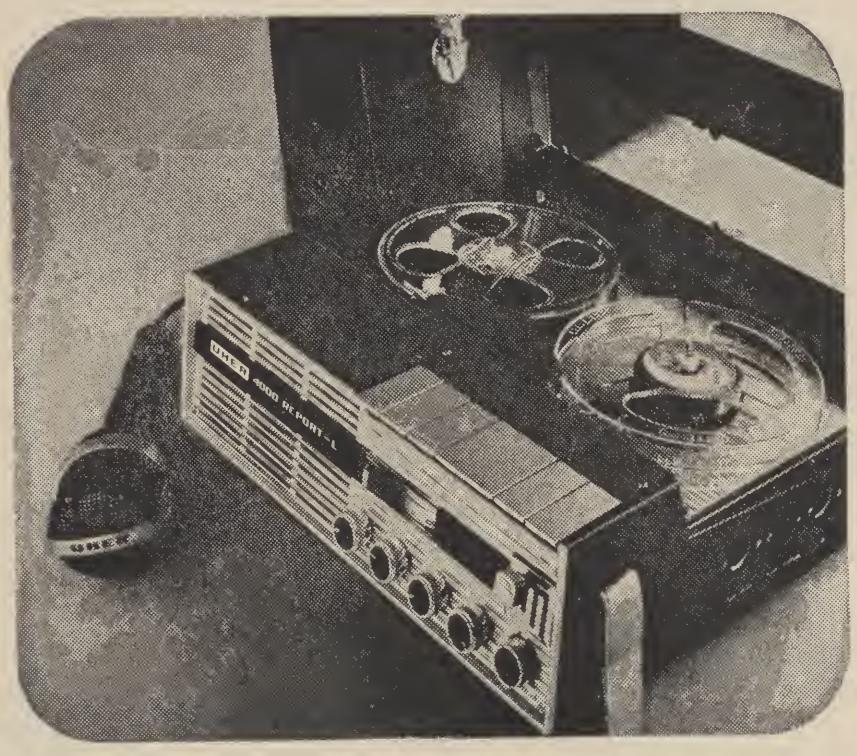
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The AMA'S Department of Investigation:

It Serves You and the Public

When the American Medical Association was founded 121 years ago as a means of propelling American medicine out of its then "Dark Ages," one of its chief goals was to protect the public from health quacks, charlatans and pretenders.

If those concerned early-day physicians could somehow be given a miraculous glimpse into the 1960's, they might be disheartened, but perhaps not surprised to find that their lofty goal of driving quackery into everlasting oblivion has not yet been reached.

Although great strides have been made against quackery through the years, the battle is far from won. Because of man's inherent weaknesses, quackery most likely never will be completely uprooted. Unfortunately for both man and medicine, the glib, fast-footed quack too often is as adaptable as a chameleon in his relentless, yet often lucrative struggle for survival.

Spearheading the unremitting attack against the many ruthless forms of health quackery that endanger health and bilk victims of an estimated billion dollars a year is the AMA's Department of Investigation, which has many powerful allies in its vigilant quest.

Chief among them are the Food and Drug Administration, Post Office Department, Federal Trade Commission, National Better Business Bureau, American Pharmaceutical Association, American Cancer Society, Arthritis Foundation and numerous other public and private agencies, including all law enforcement bodies.

Serving as a clearing house for information on quackery, pseudo medicine and nostrums, the Department of Investigation's staff of 11 persons has meticulously amassed and catalogued the most extensive files available on quackery. These files are used daily in exposing quacks.

Since quacks and other medical pretenders are quite clever and so changeable in their methods, the staff is constantly on the alert for new guises as well as the old. Although the department has no law enforcement powers, much of the information it gathers, through state and local medical societies and through its own initiative, is used by federal, state, local and foreign law enforcement agencies and state licensing agencies to prosecute offenders.

One of its key roles is to alert regulatory agencies when circumstances point to the likelihood that the laws which such agencies are obliged to enforce are being violated.

The department, created in 1906, is the brainchild of the late Arthur Cramp, MD, who, as associate editor of the *Journal of the American Medical Association,* started what was then called the Department of Propaganda for Reform in Advertising of Patent Medicines. Doctor Cramp was a most effective campaigner.

In that era, inquiries concerning quackery came primarily from physicians. That was the heyday of nostrums blatantly promising cures of diabetes or cure and alleviation of such conditions as tuberculosis, venereal disease and diphtheria. Most such nostrums, through regulatory action, have faded from the scene, being replaced by more timely "wonder cures."

Today's "merchants of menace" have adapted to the times, finding that their livelihood is greatly enhanced by such phony, but readily salable wares as baldness cures, sea water products, insomnia treatments, breast developers, cancer cures, useless vitamins, height increasers, all-purpose spinal adjustments and cures for the tobacco habit.

Since health education of the public is mandatory to thwart exploitation of the fearful, sick and the retarded, many of the department's efforts in recent years have been concentrated in this area with increasingly productive results. Widely diversified literature, exhibits and films—all part of this positive AMA program—have spurred greater public understanding of quackery and its evils. Today the majority of the thousands of inquiries annually directed to the department originate from the public.

Numerous quacks have been driven out of their thriving "practices" because of greater public understanding and coordinated efforts on the part of the AMA, medical societies and agencies equally concerned with the problems. Many of their phony products no longer are marketable. Other quacks, although still plying their trade, have been forced into exile by the close watch of

regulatory bodies.

Cancer "cures" such as the liquid and pills concocted by the late "Dr." Hoxsey, "gregomycin," which was conveniently unearthed from the backyard of another medical pretender and the more recent "krebiozen" have disappeared from the scene because of professional surveillance and ensuing regulatory action.

Thanks to quick action by the AMA, the Ohio State Medical Society and the Cleveland Academy, along with regulatory bodies, another alleged cancer cure, the "Rand vaccine" was halted before it had a chance to "make a name for itself" by creating false hopes. After initial publicity in the lay press, cancer victims from throughout the world flocked to Cleveland to obtain this substance. Another potential "krebiozen" fiasco was avoided when a federal district court ultimately barred both the manufacture and distribution of the substance.

Hard times are falling on other impostors through similar action, such as Antonio Agpaoa, the self-styled "psychic surgeon" of the Philippines who has specialized in treating Americans. Alerted by the AMA, the U. S. State Department, Philippine Medical Association and government agencies are keeping a close eye on the situation. A group of more than 100 Detroit hopefuls recently visited Agpaoa. His "treatment" was branded as a "cruel hoax" upon their return.

Inroads also have been made against "dipyrone," a dangerous drug being dispensed across the border by Mexico physicians. Several deaths occurred among arthritis sufferers in several Southern states before Louisiana physicians, the AMA and others could determine the cause and issue public warnings.

In Tijuana, Mexico, still more cancer "cures" have sprouted. Despite public warnings, however, a ready supply of hopeful patients is available. As a "service" to these patients, free bus service from California is provided. Their cancer treatment in Tijuana? Drugs found to be worthless by U. S. authorities.

In the meantime, the AMA, through the Department of Investigation and other arms, is utilizing every weapon at its command to halt the spread of quackery.

And, you, as a physician, can do your part by keeping in touch with the Department of Investigation and making good use of the services and the educational literature which it has developed for the benefit of the profession and the public.

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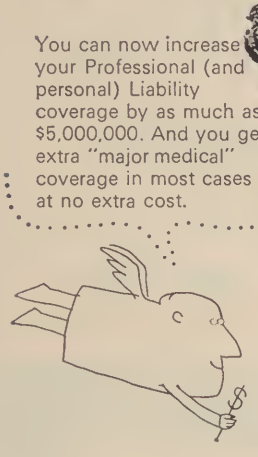
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Brief summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

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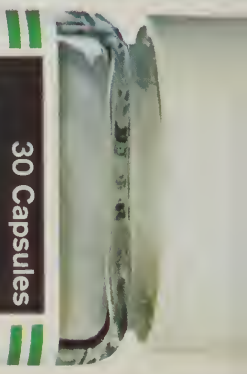


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30 Capsules
Allbee® with C

Each capsule Contains:

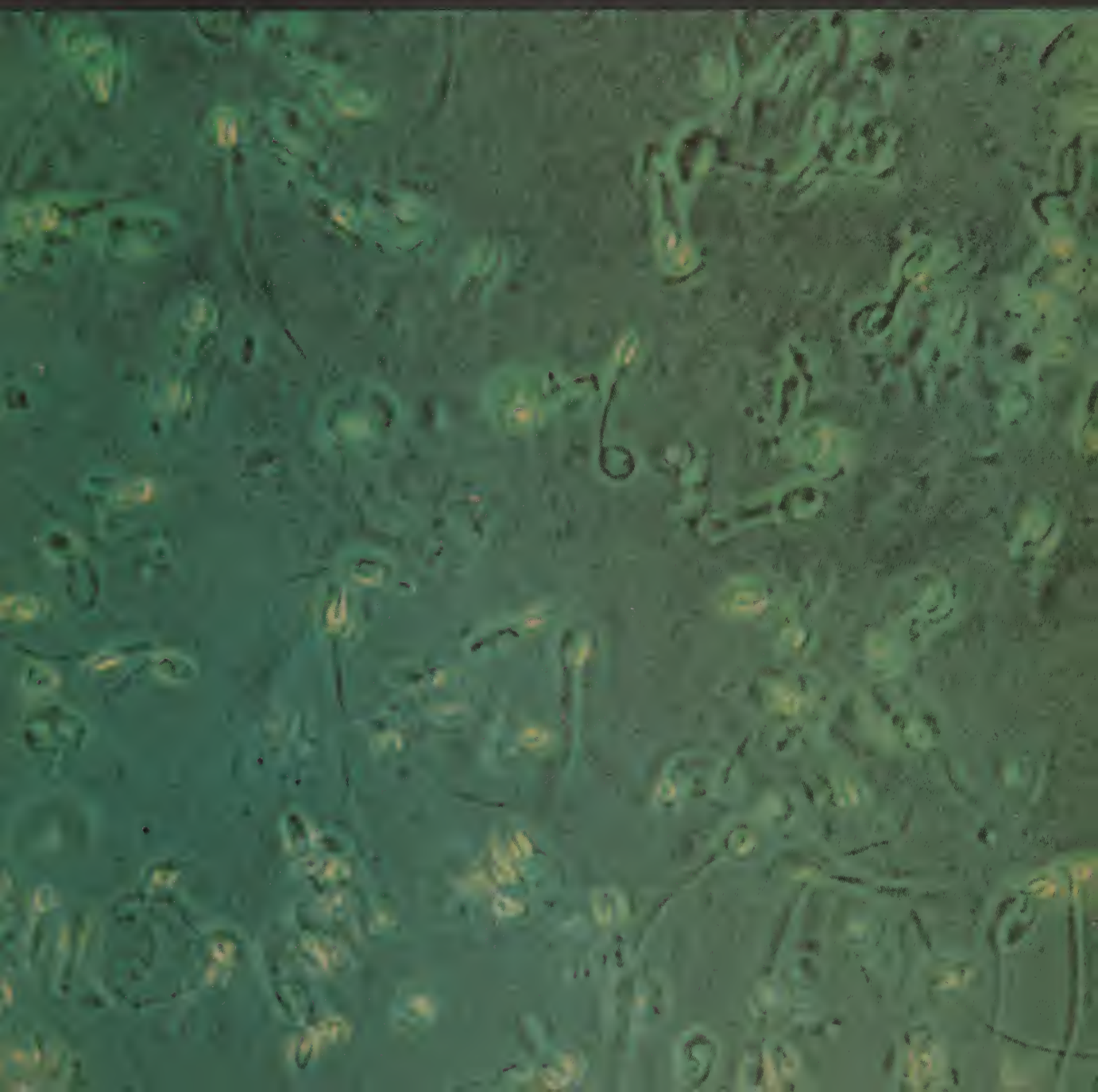
Thiamine mononitrate (Vit. B_1)	15 mg
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Pyridoxine hydrochloride (Vit. B_6)	5 mg
Niacinamide	50 mg
Calcium pantothenate	10 mg
Ascorbic acid (Vit. C)	300 mg



When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. & mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of NORINYL-1 (norethindrone 1 mg. with mestranol 0.05 mg.) in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with NORINYL-1. Therefore, if such tests are abnormal in a patient taking NORINYL-1 it is recommended that they be repeated after the drug has been withdrawn for two months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibromyomata may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. 5. NORINYL-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, and as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged NORINYL-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving NORINYL-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. 11. Because of the effects of estrogens on epiphyseal closure, NORINYL-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with NORINYL-1 may mask the onset of the climacteric. 13. The pathologist should be advised of NORINYL-1 therapy when relevant specimens are submitted.

Side effects observed in patients receiving oral contraceptives: The following adverse reactions have been observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression.

Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching.

The following occurrences have been observed in users of oral contraceptives (a cause and effect relationship has been neither established nor disproved): thrombophlebitis, pulmonary embolism, neuro-ocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, Factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

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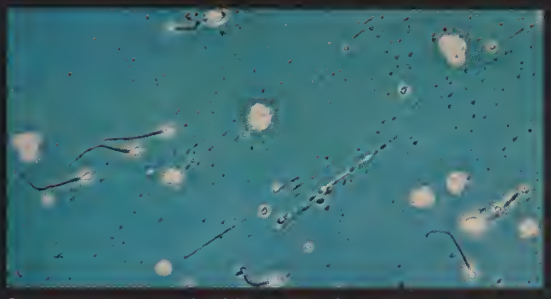
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

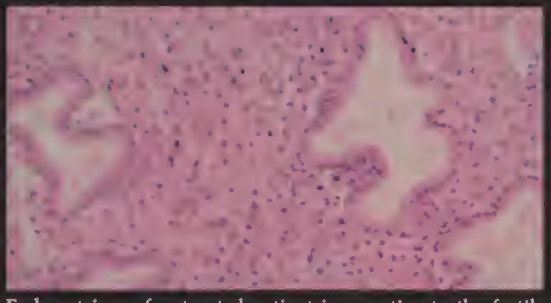
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.



Spermatozoa appear healthy, active, freemoving.

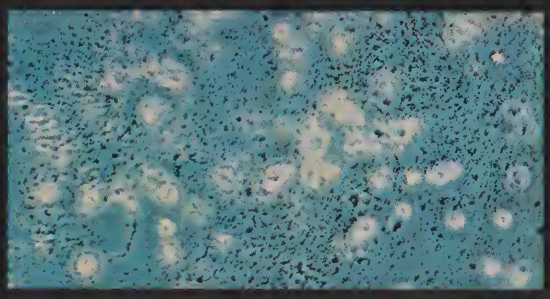


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

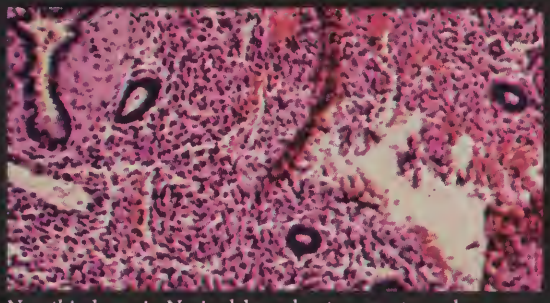
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



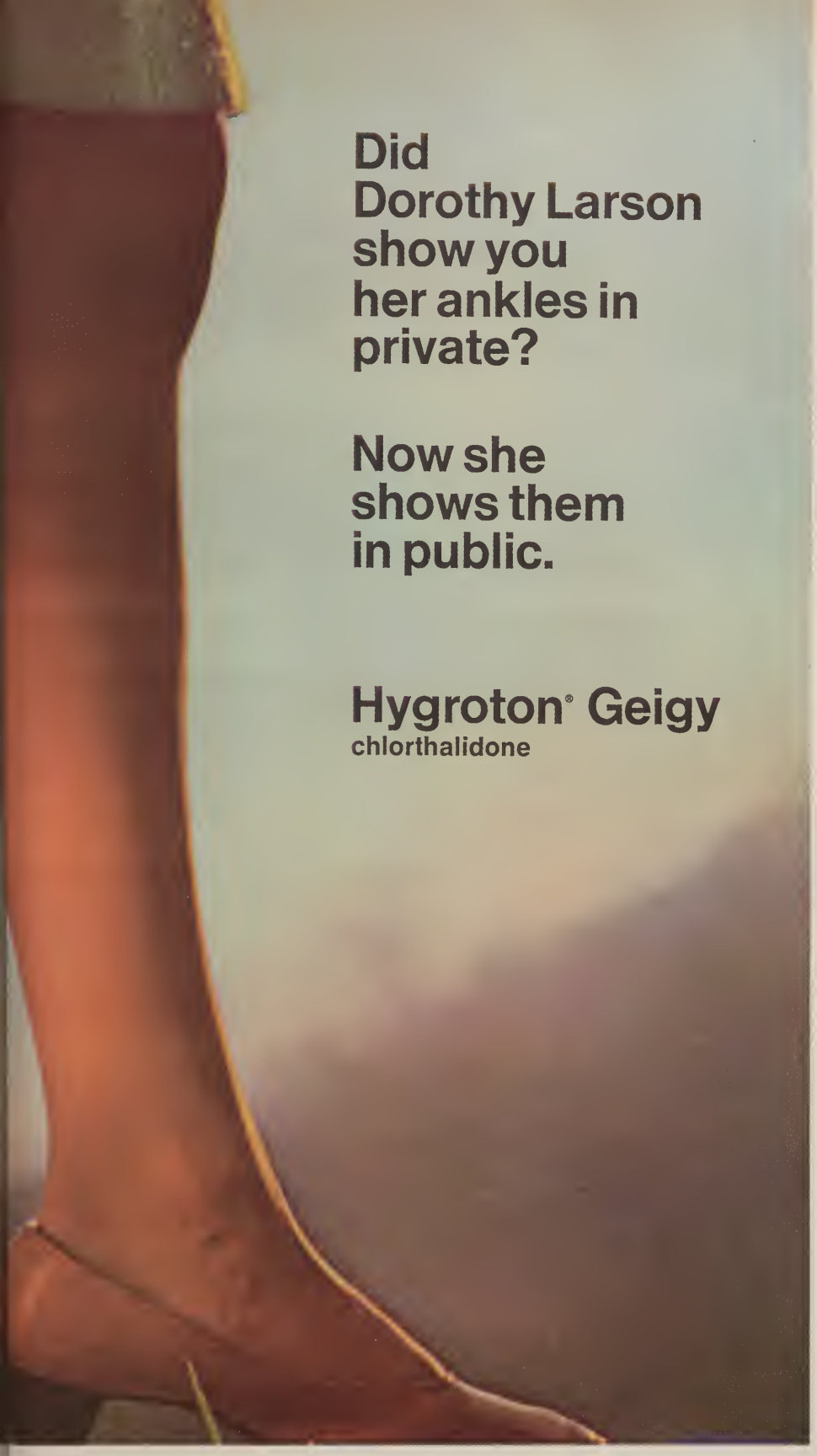
Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

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- new low dose of time-proved ingredients
- established norethindrone/mestranol ratio
- lower patient cost



Indications: Hypertension and many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Use with caution in pregnant patients, since the drug may cross the placental barrier and adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.
Precautions: Antihypertensive therapy with Hygroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Hygroton should be discontinued and potassium supplements given, provided the



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tient does not have marked oli-
ria.
ke special care in cirrhosis or
vere ischemic heart disease and
patients receiving corticoste-
ids, ACTH, or digitalis. Salt re-
riction is not recommended.
verse Reactions: Nausea, gastric
itation, vomiting, anorexia, con-
pation and cramping, dizziness,
akness, restlessness, hyperglyc-
mia, hyperuricemia, headache,
scle cramps, orthostatic hypo-
tension, aplastic anemia, leuko-
penia, thrombocytopenia, agranu-
locytosis, impotence, dysuria,
transient myopia, skin rashes, urti-
caria, purpura, necrotizing angiitis,
acute gout, and pancreatitis when
epigastric pain or unexplained G.I.
symptoms develop after prolonged
administration. Other reactions re-
ported with this class of compounds
include: jaundice, xanthopsia,
paresthesia, and photosensitization.
Average Dosage: 50 or 100 mg. with
breakfast daily or 100 mg. every
other day.
Availability: White, single-scored
tablets of 100 mg. and aqua tablets
of 50 mg., in bottles of 100 and 1000.
(B)R46-230-D
**For full details, please see the com-
plete prescribing information.**

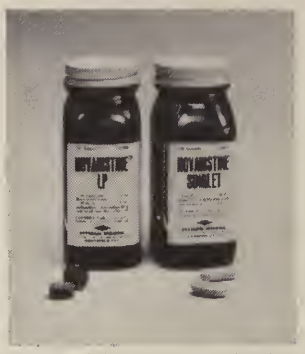
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Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

With Novahistine LP tablets and Novahistine Singlet™ tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever. Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

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PENINSULA GENERAL FINDS VISUAL CONTROL PANELS SIMPLEST WAY TO KEEP TRACK OF PERSONNEL AND PATIENTS

It's no secret that hospital personnel are difficult to keep track of.

There are so many categories of para-medical personnel, each with its own skills and areas of duty, that a simple, universal means of quickly determining who is filling work assignments has not come into general use.

Peninsula General Hospital, a 200, going on 265-bed hospital in Edgemere, Long Island, has found the answer to the problem in a visual control panel system that has removed the time consuming uncertainty and headaches of maintaining duty rosters, and patient care information.

The system's simplicity has caused an almost embarrassed reaction from staff members for "not having it long ago."

Until a few weeks ago, Director of Nurses Anita Nussdorf's job was not so simple. She has the weekly responsibility of assigning 247 of Peninsula's personnel to 12 nursing stations. Under the old system, she recorded assignments on large sheets of lined paper. During the week, they were referred to constantly with much head-scratching to keep track of and make changes in the various assignments.

Today, Mrs. Nussdorf has only to peek over her shoulder at a "Visual Control Panel" to learn at a glance every bit of information she needs know about the assignment.

Made by Acme Visible Records, Inc., the panel is of a type that has been sold to industrial and commercial organizations for years for quick visual monitoring of everything from perpetual inventories to the identification of trucks on the



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1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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road. Its fortuitous application of the panel to Mrs. Nussdorf's problem is a recent extension of its use.

A further extension of this principle at Peninsula General is the use of *satellite* control panels at each of the nursing stations to enable quick access to information about patient care.

Procedure for maintaining the panels is not difficult. Each Sunday, Mrs. Nussdorf posts names on the panel to sections representing various assignments for each day of the week. The names are held in place by plastic tabs or "signals," as they are called, in the panel's tubes. These signals are colored differently for each personnel category. Thus, registered nurses are pink, licensed practical nurses are green, aids red, orderlies blue, and so on. In addition, small green or red plastic signals are slipped on next to the names to indicate each employee's availability on given days. Red signals are used to indicate holidays, vacation and sick days.

"I have only to glance over my shoulder to see the personnel lineup at the hospital for the week," Mrs. Nussdorf said. "If shortages develop at any point, personnel to fill them can be found in seconds and reallocated by referring to the panel. When calls come in for any personnel, they can be referred immediately to the proper station."

At each nursing station, a similar panel maintained daily by the medication nurse, displays the nursing-care plan for the entire station. This panel offers such information as patient's name and room number, his physician's name, his scheduled medications, treatments, X-rays, diet, status (eg, ambulatory), and the nurse assigned to him.

Much appreciated by physicians is that each doctor's patients are assigned the same color plastic signals. The doctor can spot his patients quickly by referring to his personal color.

Changes in the Visual Control Panels can be made quickly at any time to reflect changes in personnel assignments, patient status or other new information. Their flexibility and fast presentation of important information at Peninsula General has brought nods of approval from everyone there from board members down.

"The panels have simplified our planning and scheduling so much," concludes Mrs. Nussdorf, "that we wouldn't be without them now."

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THE JUNE CONVENTION—"KEEPING UP"

Demands placed upon the American health care system have made the health services industry the nation's fastest growing employment field, American Medical Association president Milford O. Rouse, MD, pointed out in a year-end report.

"Fifteen years ago it was the fifth largest employer, now it is third," said Dr. Rouse. "If present trends continue, it will become the nation's No. 1 employer by the early 1970s."

Few physicians need instruction in the facts concerning increasing demand. In addition to the growing claims upon him by patients, medical society, hospital, civic affairs, and family, the physician faces his responsibility to himself to "keep up" with medical developments.

The year-around task of "keeping up" is manifested by the stack of medical journals, which is regularly attacked but often seems to be self-regenerating.

Once a year, the physician has an opportunity to spend the better part of a week doing nothing but "keeping up" at world's largest medical meeting, the Annual Convention of the American Medical Association.

This year, the 117th Annual Convention of the AMA will be held June 16-20 in San Francisco. The Civic Auditorium, War Memorial, Opera House, and several nearby hotels will house the scientific program; the House of Delegates will meet in the Fairmont Hotel.

Approximately 600 scientific papers are to be presented, and more than 250 scientific exhibits will be on display as well as many industrial exhibits.

General Scientific Meetings Planned

Among special presentations planned are four General Scientific Meetings on automobile accidents, health care planning, management of

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infectious diseases, and treatment of advance malignant disease.

—Automobile Accidents, with participation by Sections on Orthopedic Surgery, General Surgery, Pediatrics, Physical Medicine, and Preventive Medicine, as well as the AMA Committee on Medical Aspects of Automotive Safety.

—Health Care Planning, with participation by Sections on Preventive Medicine, Diseases of the Chest, General Practice, General Surgery, Internal Medicine, and Military Medicine.

—Management of Infectious Diseases, with participation by Sections on Experimental Medicine and Therapeutics, Allergy, Diseases of the Chest, General Surgery, Pediatrics, and Preventive Medicine.

—Treatment of Advanced Malignant Disease, with participation by Sections on General Surgery, Gastroenterology, General Practice, Internal Medicine, Nervous and Mental Diseases, Pathology and Physiology, Colon and Rectal Surgery (formerly Proctology), and Radiology.

Also, regular scientific programs will be presented by each of the 22 Scientific Sections, plus a program by the Section on Miscellaneous Topics. The latter program will include a full-day session on smoking and health sponsored by the AMA Committee on Research for Tobacco and Health, and a full-day session on neurological surgery in which the American Association of Neurological Surgeons will participate.

The entire scientific program will appear in the May 6 issue of the *Journal of the American Medical Association*.

International Science Fair Winners will Participate

The youngest exhibitors and official guests of the AMA at its Annual Convention will be two teenage high school scientists.

They will be chosen at the 19th International Science Fair in Detroit May 15-18 by members of the AMA Council on Scientific Assembly. Competing with over 400 other finalists from every state and several foreign nations, the two top AMA winners will be named for the excellence of their studies and exhibits in the basic medical sciences.

During the Convention, they will exhibit their displays in the Scientific Exhibit and will be introduced as honored guests of the AMA to the House of Delegates, the Woman's Auxiliary to



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the AMA, and at the Scientific Awards Dinner.

The AMA has been participating in the International Science Fair for 13 years as part of its program to attract superior students to the study of the medical and health sciences.

Medical Motion Pictures/Color T.V.

Approximately 50 medical motion pictures will be shown as part of the scientific program at the convention.

Color television, presented live from a San Francisco-area medical facility, also will be featured.

The medical motion picture program will include the premiere of a new film on "Diagnosis of Heart Disease," made with the sponsorship of the American College of Cardiology. Narrator of the film is Tinsley Harrison, MD, Distinguished Professor of Medicine, University of Alabama, an internationally known authority on diagnosis of the causes of cardiac pain.

Other films to be included are "Radiographic Visualization of the Biliary System and Cholecystectomy and Choledochotomy," by Frank Glenn, MD; "Bullet Embolus of the Right Ventricle," by Arthur Beall; "Role of the Endometrium in Conception and Menstruation," by John Rock, MD; and, "Cold Light Endoscopy," by Norman P. Schenker of Munich, Germany, an award-winning film made in France, Germany and Austria.

Five Scientific Sections are to present programs on color television: Dermatology, case presentations; General Surgery, a surgical program including live telecast of an operation, moderated by J. Englebert Dunphy, Professor of Surgery, University of California; Laryngology, Otology and Rhinology, a program on sinus diseases; Obstetrics and Gynecology, the complete gynecologic examination; Orthopedic Surgery, spine problems in children.

Woman's Auxiliary Program

An afternoon of continuous health education films including films on sex education, drug abuse, physical fitness and nutrition will be a new feature at the 45th annual convention of the Woman's Auxiliary to the American Medical Association.

More than 2,000 physicians' wives are expected to attend the June 16-20 meeting at the St. Francis Hotel, in San Francisco. Auxiliary president, Mrs. Karl F. Ritter of Lima, Ohio, will preside.

On Sunday, June 16, the Auxiliary will hold a reception for their president, Mrs. Karl F. Ritter, and president-elect, Mrs. C. C. Long of Ozark, Ark.

The Monday luncheon will honor the leaders of women's volunteer organizations throughout the United States.

Milford O. Rouse, MD will be the guest speaker at the Tuesday luncheon honoring national Auxiliary past presidents and AMA Officers and Trustees and wives. At this time the Auxiliary will present its annual contribution to the American Medical Association Education and Research Foundation. (Last years' gift totaled $384,649.48.)

Following this luncheon, films will be shown for the remainder of the afternoon. This new feature will provide Auxiliary members with a catalog of available health education materials to be used in conjunction with existing Auxiliary programs.

The Auxiliary will also sponsor a program of daily activities for the pre-teens and teenagers of Auxiliary members. Local arrangements for the convention are under the direction of Mrs. Lloyd Gillin and Mrs. Don C. Musser, both of San Francisco.

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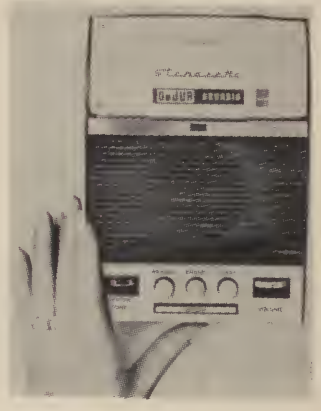


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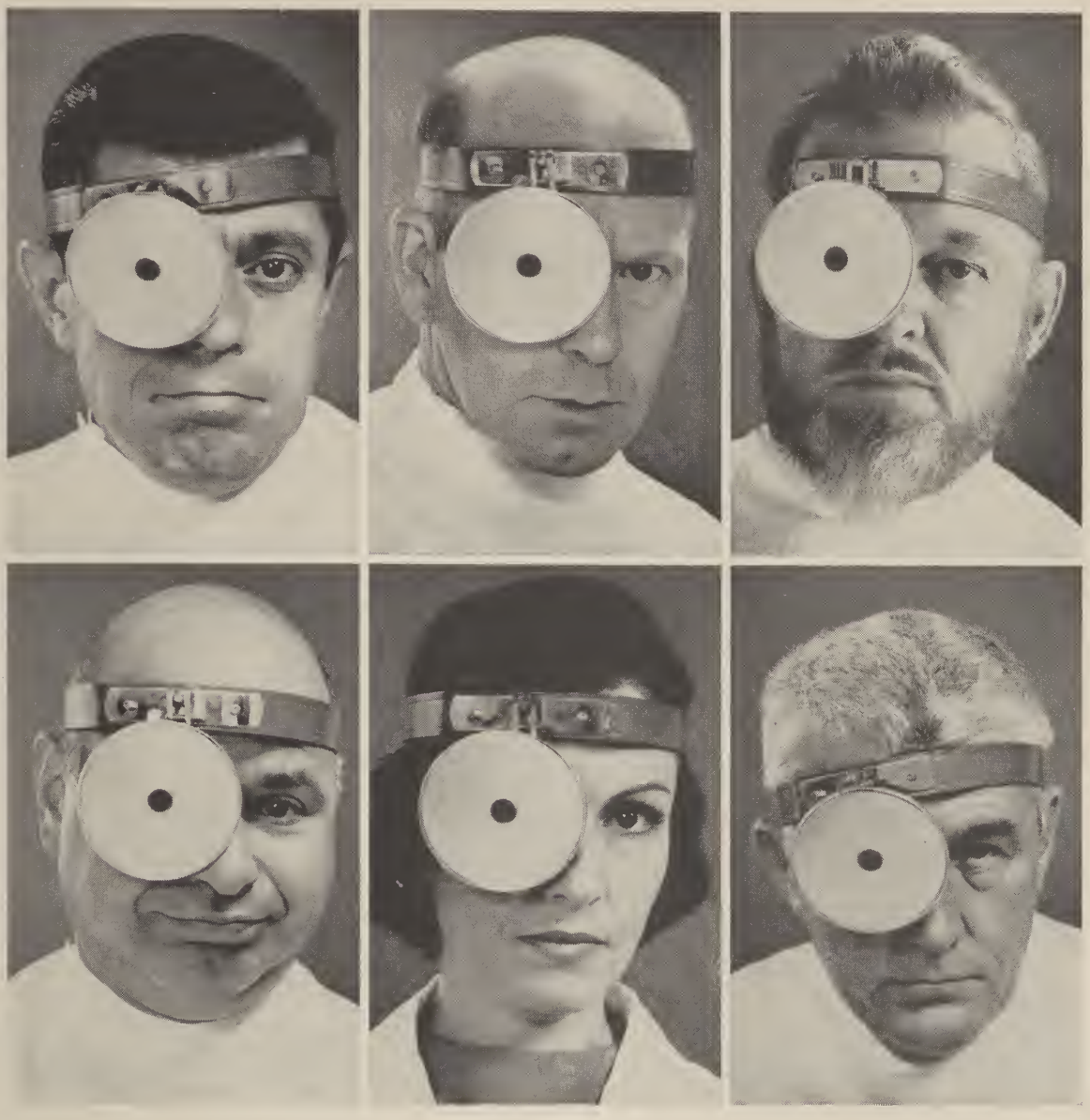
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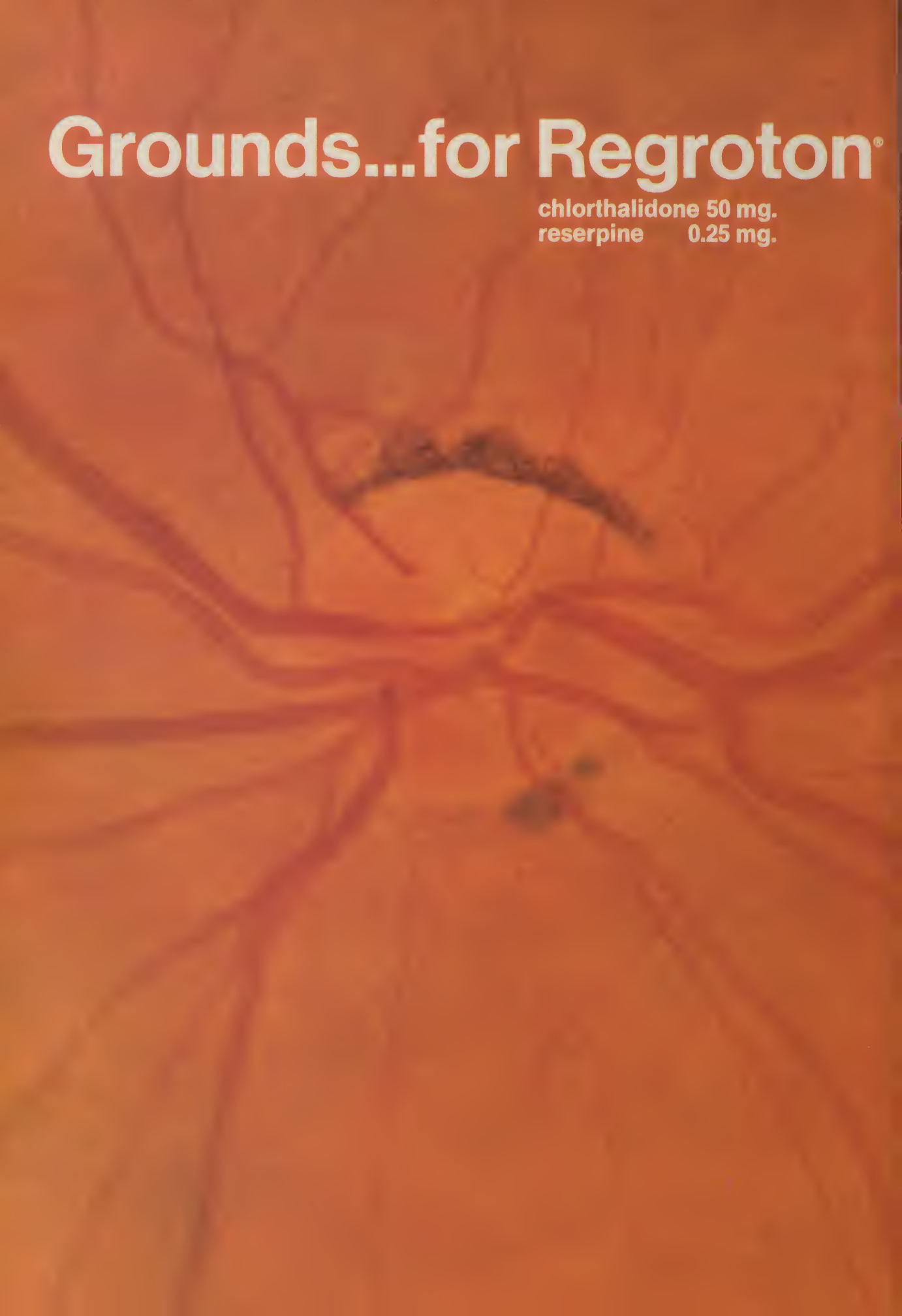
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Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with immediate gastric lavage and appropriate supportive therapy (CNS stimulants and pressor amines as indicated).

Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness. Overdosage may result in CNS depression (drowsiness and lightheadedness) or CNS stimulation and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]). Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically such as with epinephrine, antihistamine and possibly hydrocortisone. A few cases of leucopenia, usually transient, have been reported following continuous use. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

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See last page for contraindications, precautions and side effects.

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The propylene glycol vehicle of Synalar Solution possesses many useful cosmetic properties. Clear and greaseless, it is not sticky or messy, will not stain clothing or skin. In exposed areas of the body where cosmetic appeal is important, Synalar Solution shows nothing but results.

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Because of the properties of propylene glycol and the milligram potency of fluocinolone acetonide, a small quantity of Synalar Solution goes a long way. Also, the prescription price of a 20 cc. plastic squeeze bottle of Synalar Solution is surprisingly low. Thus, your patients obtain economy with the proved efficacy of a potent, truly advanced topical corticosteroid.

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components.

Precautions: In some patients with dry lesions, the solution may increase dryness, scaling, or itching. Application to denuded or fissured areas, such as genital or perianal sites, may produce a burning or stinging sensation. If this persists and dermatitis does not improve, discontinue medication. Although propylene glycol has antiseptic activity, there should be careful initial evaluation and follow-up of infected sites. Incomplete response or exacerbation of lesions may be due to true infection, which requires susceptibility testing and appropriate therapy. On the other hand, saprophytic or low grade infections may clear spontaneously under the influence of Synalar Solution alone. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

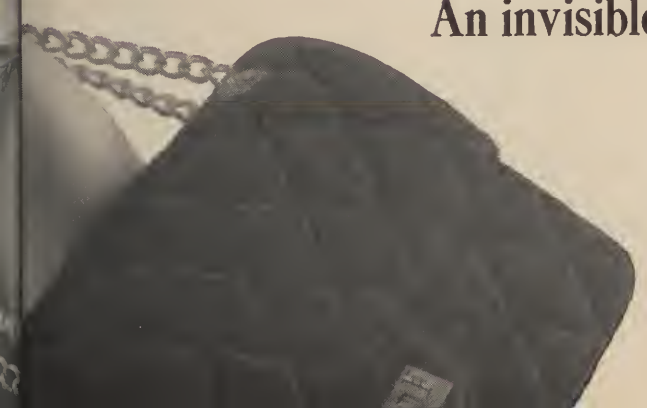
Side Effects: Side effects are not encountered ordinarily with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions.

Availability: Synalar (fluocinolone acetonide) Solution 0.01% in a propylene glycol vehicle with citric acid as preservative. 20 and 60 cc. plastic squeeze bottles. *Also available:* Synalar (fluocinolone acetonide) Cream 0.025% —5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream—5, 15 and 60 Gm. tubes.

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Radium Losses Prevented by Special Container

A special container to prevent radium losses during shipment has been developed at the Public Health Service's National Center for Radiological Health as a means of eliminating a cause of environmental contamination by radiation.

The development coincides with a recent rise in radium losses during shipment. The most recent incident occurred last June and involved the loss of 18 radium needles. Several of these remain unrecovered despite intensive searches by local, State, Federal, and private radiation specialists along the shipping route from San Diego, California to New York, New York.

"Radium needles and capsules, no more than a half inch long and an eighth of an inch thick, can be seriously harmful to health unless properly used by a physician or other qualified professional," said James G. Terrill, Jr., Director of the National Center for Radiological Health.

"A single needle may cause radiation burns if picked up by a person unaware of the hazard and carried for several hours," Mr. Terrill said. "Moreover, these sealed radium sources, when not properly packaged, can be broken. This, in turn, can spread radioactivity, with its threat of short-term or delayed health effects, over relatively large areas through the release of the encapsulated radium salts."

The shipping container is reusable. It has been designed specifically for medical radium capsules and needles in the commonly used sizes. It may be adapted readily, however, for radium-beryllium neutron sources and may be modified to provide a container for plaques and nasopharyngeal applicators. Development of the container primarily was the work of Frank B. Conlon, a Radiological Health Center engineer.

The container is, in effect, an interlocking of interior and exterior containers. These cannot be closed until one has been made fast to the other so that there can be no internal movement or accidental opening during shipment.

The interior container is in three sizes, each made to hold a maximum of either 50, 150, or 300 mg of radium. Each size is fabricated in two parts of threaded hexagon brass stock with bottom portions drilled to receive a limited number of radium capsules or needles of a given size. Bottoms and tops are tightened against a metal gasket to prevent leakage of radioactive gas which could occur with leaking radium needles or capsules.

The interior container is locked into the center of a cylindrical, lead-lined shield. This is accomplished by means of a plug-shaped closure in which the interior container is held fast by a spring-loaded device. The plug may be inserted and locked into the shield by a spring-loaded bayonet type lock, but only if the interior container has been properly positioned in the plug and is of a size suitable for a given shield.

The interlocked interior container and shield are secured in the center of the exterior container by engaging the shield in slotted channels built diagonally in the bottom and top of the container. The upper channels are so aligned that the exterior container may not be closed unless the shield closure is in a fully locked position. The exterior container, an 18-inch cube constructed of one-quarter inch plywood and metal corner mouldings, is sized to meet the dose rate requirements of transportation agencies with a minimum amount of lead shielding.

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PRECAUTIONS: (1) Desipramine hydrochloride should not be substituted for hospitalization when risk of suicide or homicide is considered grave. Suicidal ingestion of large doses may be fatal. (2) If serious adverse effects occur, reduce dosage or alter treatment. (3) In patients with manic-depressive illness a hypomanic state may be induced. (4) Discontinue drug as soon as possible prior to elective surgery.

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Editorial

Maryland State Medical Journal
Vol. 17, No. 4
April, 1968

"Carthagina Delendenda Esse" (Cato the Elder)

Have we of the medical profession attained such a degree of corrosion that we are about to abdicate our rights and ways of practicing medicine as we see fit?

Are we about to permit outside organizations, motivated by self interest, to regiment us and those who will follow in our footsteps?

P. Bonnett, MD, past President of AHA, feels that the ultimate goal in medical care will not be attained until all physician's salaries are paid from a "Broad Based Pool under private or government auspices." This spells financial control of our profession, it means that we become employees of Hospital or Government, and as such we lose power of self determination.

What these organizations have achieved or proposed to achieve comes from a "Unity of Purpose" tantamount to a collusion between Hospital Administrators, Blue Cross, and allied organizations. Coercion is achieved through monolithic rules passed by these organizations, and if this fails, then financial strangulation will prevail through Blue Cross' power.

This *Unity of Purpose* is readily understood when one analyzes the composition of these various organizations. Membership in Blue Cross is overwhelmingly made of Hospital Administrators. The State Hospital Associations are composed entirely of Hospital Administrators. There is no better example in existence of conflict of interest than the one demonstrated by the overlapping interest of these various organizations. I call, and have called attention to this conflict of interest concept because Hospital Administrators, Blue Cross people and other organizations have been so very prone to invoke this concept as a pet device, as a spurious argument to prevent physicians from exercising their due rights. It is time for us of the medical profession to face facts, to realize that in Hospital Administrators, Blue Cross Administrators, State Hospital Administrators, we have organizations with the avowed *Unity of Purpose* to govern the practice of medicine. To this effect they will oppose us when their interest and ours conflict. To this effect they will seek government help to regulate us when there is conflict between their interest and ours.

Finally, it is with alarm that we should view the efforts of Hospital Administrators who attempt to extend the medical practices of Hospitals by employing physicians in fields other than radiology and pathology.

The remedy is clear and simple, we physicians must devote more time to the administration of Hospitals. We must seek and demand the appointment of medical men as Trustees of Hospitals. In this way we can participate in the deliberations of the Boards of Trustees and prevent decisions that would undermine the freedom of medical practice.

R. F. ARCHAMBAULT, MD

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"Medicine was in the beginning and still is primarily personal in its activities; but with time and the growth of civilization, it has become more and more interwoven in the whole fabric of human society."—Ray Lyman Wilbur, '96 AM '97

Medicine in 1923 was like a giant awakening to discover that it existed as a great scientific and social force in society. For 150 years it had been trying to disentangle itself from magic, to establish itself on a sound scientific basis and to raise standards of medical education to those of the graduate level in the university. Great credit must go to the pioneers in scientific medicine of that period who were in large part responsible for bringing it to the point in 1923 where the public in this country and Europe was beginning to recognize medicine as a powerful force for good in our society.

THE MARCH OF MEDICINE 1923-1968

DWIGHT L. WILBUR, MD*

**Dr. Dwight L. Wilbur, '23, president-elect of the American Medical Association, is in a unique position from which to reflect upon scientific advancements and social changes which have affected the practice of medicine. Forty-five years ago his father, the late Ray Lyman Wilbur, '96, was elected to the same post. A prolific speaker and writer, the former Stanford President left a fine legacy of thoughts about the role of the doctor. His son has prepared this comparison of the practice of medicine in 1923 and 1968 specifically for our Stanford audience.*

An internist with a practice in San Francisco, the author received his medical degree at the University of Pennsylvania and spent several years at the Mayo Clinic before returning to the West Coast. He has served his profession and his alma mater in many capacities and for a number of years has been a clinical professor of medicine at Stanford.

The legacy of Stanford affiliation left by Ray Lyman Wilbur and his wife, the former Marguerite Blake, '98, is well entrenched in the Dwight Wilbur family. The AMA president-elect and his wife, Ruth Jordan Wilbur, '27, are the parents of Dwight L. Wilbur III, '51, MD '55, Jordan R. Wilbur, '53, MD '61, and Gregory F. Wilbur, '56, MBA '60. Dr. Jordan Wilbur, assistant professor of pediatrics at the Medical School, is a third-generation faculty member.

SOURCE: STANFORD ALUMNI ALMANAC
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1923

The great challenges facing medicine and the physician in 1923, when my father, Dr. Ray Lyman Wilbur, was inaugurated as president of the American Medical Association, were well expressed by him in his Presidential Address: To put medicine increasingly on the foundation of basic medical sciences, to use the experimental methods of science in medicine, to elevate the standards of medical education, to recognize the physician-patient relationship as a factor of pervasive importance in the practice of medicine, to appreciate the benefits of preventive medicine and public health measures and to properly understand the great social forces changing the relationship of medicine to society.

Looking back now, medicine in those days seemed fairly simple. Practice was carried on largely by the individual, a solo general practitioner—the beloved family doctor, so busy in the care of his patients that often he was unaware of the great changes taking place in medicine and in society about him. Skillful though he was in the

art of medicine, the science of medicine he practiced commonly was based on a very limited background of didactic teaching he had received in medical school. He was aware of specific causes of certain infections, such as tuberculosis, syphilis, pneumonia and typhoid fever. He knew how to diagnose them and to obtain proof in the laboratory that his patients had them. He could with X-rays and laboratory tests widely extend his diagnostic capabilities. He clearly understood the great public health measures in the prevention of disease. He encouraged vaccination against smallpox and often typhoid fever.

For the most part the drugs he used were for symptom relieving purposes. Derivates of opium, of digitalis, of salicilates like aspirin, of bromides and other simple sedatives were his main tools in the treatment of disease. The only real chemical cures of diseases he had were salvarsan—the famous 606—for syphilis, quinine for malaria, and arsenicals for amebiasis. Surgical treatment had advanced greatly in the preceding 20 years but it still carried a considerable mortality, was in large part limited to removal of diseased organs, and was often carried out by practitioners without expert training. It did not have the sound scientific basis of later days. In practice, diagnosis was good although limited, treatment was in large part symptomatic or surgical, and each was provided in a setting with as much of the art of medicine as the physician was capable of providing or willing to bestow.

Medical education in the early 1920s was undergoing changes that were deep and wide, largely owing to the efforts to implement the Flexner report of 1910, which laid the groundwork for the modern scientific university-based medical school. The evolution of the Stanford Medical School is a good case in point. Initiated as a proprietary medical school by Elias Samuel Cooper in 1853 and revived and greatly accelerated by his nephew, Levi Cooper Lane, it was in 1910 taken over as the medical department of Stanford University. This tie to the university greatly strengthened the medical school. It became increasingly scientifically based, acquired full-time professors of extraordinary ability, and began winning its way to a high place in medical education. Since the time of the transfer of the medical school to the University campus in 1959 it has become a great medical center and a university-based, research-oriented institution.

The great moves in medical education of that period were the increasing strength of basic medical sciences—physiology, biochemistry, bacteriology, and pathology. The development of the university hospital-medical school complex with its bedside teaching, geographic full-time professors in the clinical departments, and out-patient clinics, all were the factors that revolutionized medical education in this period. What was taking place was a change from preceptorship education to a form based on self-learning, on the experimental method, and on a closer relationship between the physician, the laboratory, and the patient.

Medical research was carried out by very limited numbers of medical school faculty members. It was usually patient-oriented, effected by a single investigator rather than by a team, and was financed chiefly by private funds and foundations, rarely by government. The money spent on it was a very small part of the medical school budget.

The financing of medical care in the early 1920s was largely up to the individual patient and his family. Government long since had limited its responsibilities at the state level to persons with serious mental disease, and at the county level to those without any means of support. Charity clinics and wards were common in medical schools and many other hospitals throughout the country.

The nurse in 1923, as now, was the principal professional associate of the physician. She was usually a graduate of a hospital school of nursing (a diploma school) or self-trained. She served 12 or at times 24-hour duty, seven days a week, and usually her care was given to one patient at a time. Laboratory technicians, physical therapists, and X-ray technicians generally had little, if any, formal training; they usually learned on the job and functioned primarily in hospitals or physicians' offices. Excepting dentists and pharmacists, the great array we now know as the allied health professions and services, was in those days unknown, or was unused, or existed only in research laboratories. The health team was yet to be developed.

Hospitals were primarily supported by universities, private foundations, charitable organizations, or the state or local governments. Not uncommonly patients went to hospitals for a rest or "rest cure," as well as for serious illnesses or operations. Costs of a stay in hospital were not high, and charity or educational funds were available to care for many who otherwise would have had to seek care in a county or city hospital. Much

of the great fear of hospitals as death houses—as a place to go to die—or for chronic or incurable disease still existed, but as medicine was becoming more scientifically based these fears and apprehensions were lessening.

The role of government in medicine in the early 1920s was clearly delineated. The federal government assumed complete responsibility for the medical and hospital care for military personnel and their dependents, for veterans with service-connected and many with non-service connected disabilities, for sailors in the Merchant Marine (in U. S. Marine Hospitals), and, in a few isolated instances, for other groups. State governments assumed responsibility for custodial and, such as it was, medical care of the insane, while local governments through city and county hospitals cared for local citizens who were financially unable to meet the costs of medical and hospital care.

State and local departments of public health were oriented to the prevention of contagious and infectious diseases. This meant responsibilities in sanitation, assuring a good water and milk supply, adequate disposal of sewage, control of flies and mosquitoes, and statistical analysis of the incidence of diseases (particularly those that were contagious). The general concern was for community health, with emphasis on the control of infections.

Private foundations, such as the Rockefeller Foundation, Commonwealth Foundation, and others, played a number of very important roles in medicine in the 1920s. Of greatest importance was the financial support of a number of medical schools which permitted them to go "full time," to strengthen faculties and research, to build new buildings and hospitals, and to establish themselves at the level of a graduate school in a university. The financial support permitting implementation of the Flexner report was probably the most potent factor in advancing medical education. Further stimulation of medical research in such institutions as the Rockefeller Institute for Medical Research and in medical schools, and the support of public health measures in this country and abroad designed to control malaria, yellow fever, and hookworm disease, were developments of far-reaching importance, for beyond the immediate advances in the public health in this country and abroad, they led to the establishment of schools of public health.

This, then was the picture of medicine in the early 1920s. It seems simple now. The great challenges were to expand the knowledge and application of medical science, to provide for better medical education, to stimulate and produce research, to awaken awareness of the great role of medicine in society, and to develop a means of financing the costs of medical and health care.

1968

Forty-five years seems a short time in human affairs. But in the years since 1923, the civilized world seems to have changed completely. Rapid transportation and communication, the splitting of the atom, the control of most infectious diseases, the lengthening of life, the understanding and practical application of better nutrition, and the increasing role of government in the life of the individual and of communities and nations have revolutionized the thinking of man as well as his life and environment. Developments in medicine have played as large a role in these changes as has any other factor. Indeed this role may have been the largest and the most important.

What has happened in medicine in this period? In medical practice the greatest change has been that it is increasingly based on medical science. More has been learned in medicine in this time than was learned throughout history up to 1923. With these developments in science there has been some lessening of the art of medicine—that voluntary association of two men, one giving and one seeking relief. With the explosion of knowledge came the great era of specialization, the rise of the medical center, and the development of group practice. The spreading knowledge of the benefits of modern medicine, stimulated greatly by the experiences of millions of men and women in World War II and by care in Veterans Administration hospitals, by higher standards of education, and by mass communications media, has played a very significant role in abating fear and anxiety and in increasing demand for the benefits of what medicine has to offer.

Medical education has become increasingly costly and complicated. And for the individual student it is taking much longer because of the requirements of specialty training and military service. Today the average young physician is in his early thirties before he is ready to practice.

No facet of medical education has been more significant than the emergence of graduate medical education—the residency, the fellowship, and the training to be a specialist. The demands on the

individual and on the school have changed to the degree that the period in medical school—the "under-graduate" part of it—has become only a segment of the total medical educational process. Together the burgeoning public demand for good medical care, and the longer and more exacting educational process, have led to the development of more and larger medical schools. Concomitantly there has been a great increase in the size of medical school faculties.

Medical Research

Of all the factors responsible for the great change in medicine none has been more important than the growth of medical research. Vast sums of money, largely from the federal government, have made research institutes of most medical schools, have attracted more and more students into the basic medical sciences, have enlarged and strengthened faculties, have significantly altered the educational process and the administration of medical schools, and have led to a great spill-over of knowledge into medical education and practice. But much more knowledge is needed. Search for the cause and cure of cancer, for the control of hypertension, and for the prevention of diseases of the heart and of the coronary and cerebral arteries are among the countless practical goals sought by those who engage in medical research. Practicing physicians patiently wait for the development of new antibiotics, of new chemical agents to prevent and cure disease; for hormones and enzymes to lead to a new understanding of and treatment of diabetes, gentic defects, and countless other common problems.

No field of medicine lies more dormant or less understood nor is of greater importance than that of the study of the human mind. The potentials of psychology and psychiatry are enormous and research in these areas should lead us into better understanding, control, prevention, and relief of mental and emotional disorders—unhappiness, frustration, depression, anxiety and all those disorders which so commonly affect the individual and society.

The Committee on the Cost of Medical Care, of which Dr. Ray Lyman Wilbur was the chairman, recognized in 1932 that the provision of adequate scientific medical service to all the people, rich and poor, at costs which could be reasonably met by them in their respective stations in life, was of vital concern to everyone. The rising costs of medical care led to the development of voluntary health insurance—Blue Shield, Blue Cross and the services of insurance companies now covering, in part at least, 165 million people in this country. The demand for services and the need for financial assistance naturally led to the interest of organized groups, such as labor, in the financing of health care as a fringe benefit.

These factors led also to government participation in this important field, which at the state level began with medical care for crippled children, for the blind, for the destitute, and for others. In 1965 the federal government passed highly important amendments to the Social Security Act which established the familiar Medicare and Medicaid programs assisting persons 65 years of age and older and others who are medically indigent to get help and medical care at government expense.

Health and medicine have become matters of interest to almost everyone. The wide reporting of increasing developments in medical science to a better educated and more sophisticated public has whetted this interest. The growth of voluntary health agencies has reflected selective interest in certain diseases (for example, tuberculosis, heart disease, cancer, leukemia and poliomyelitis) and in these areas dedicated laymen, physicians, and other professionals have had wide and productive cross-fertilization of interests and activities. Unions and other employer groups, employees and the public have become well informed in the field of health and health insurance. The public press and other communications media have figured importantly in bringing health matters to the attention of the public. Candid and complete descriptions of the diagnosis and treatment of dramatic illnesses, such as the heart attack of President Eisenhower and the operation on President Johnson, had a profound educational effect. Community efforts in poliomyelitis, vaccine drives, population control, "the pill," and abortion, have brought home to many persons and families, in a practical way, knowledge of medicine and what it has to offer.

In 1968 we speak of a health care "industry." With almost five million people engaged in it, it is now the third largest in the nation. The amount spent for its "product" in 1967 is estimated at 50 billion dollars. Manned in large part by non-physicians, the health care industry has within it some 75 to 100 different categories of workers, known by physicians as "allied health professions and services." These include dentists,

nurses, pharmacists, hospital administrators, laboratory technicians of many kinds, physical, occupational, and other therapists and aides, medical secretaries, medical record librarians, and the like. For many of these groups formal education at the high school, junior college, and four-year college level or beyond is necessary, and in eight of the categories the educational program is approved by the scientific organization of those involved as well as by the American Medical Association.

The interrelationship of these various groups with physicians and one another is accomplished through what has been called a "health team." With a physician as captain, the health team under his direction can carry out a wide variety of health care services, including some that are as complicated or highly technical as, say, open heart operations. In fact in other cases, as well as minor illness, the physician calls on these people to assist him and participate in the care of patients. The composition and function of the health team will vary greatly in the setting of the university medical center or the rural area; in the hospital, clinic, or home; in the diagnosis and treatment of those with acute or chronic diseases; or in the handling of the mentally ill or the hypochondriac.

One of the most striking changes in medicine in the past 45 years has been the growth of specialties—the internist, the surgeon, the ophthalmologist, the dermatologist, and such. With this change has come a decline in the number of general practitioners, now often called family physicians. Efforts to reverse this process, lamentable to many who revered and relied so heavily on the "family doctor," are under way but how successful they will be remains to be determined. The trend toward specialization has led to great strength of specialty organizations, such as the American College of Physicians, the American College of Surgeons, and the academies, colleges, and associations of other groups. Most importantly, these groups have led to higher standards of education and practice, to consideration of high quality of care, and, in association with the American Medical Association, to the development of specialty boards. Also new is the Joint Commission on Accreditation of Hospitals, which sets and measures standards of care in hospitals, extended care facilities, and the like. Furthermore, these associations have participated actively in and stimulated development of programs in continuing medical education to keep practicing physicians up to date. No other profession has done so much to raise the standards of the services rendered by its members.

The shrinking of the world by rapid mass transportation and easier and frequent communication—together with the great involvement of the United States in military activities, government aid, and the needs of developing countries—has made many American physicians very knowledgeable in the fields of international medicine and health. Efforts to eliminate malaria and other infectious diseases, and to strengthen schools for medical and health professional personnel, have been significant but are largely in their infancy. At the same time, the tide of physicians coming to the country to learn, to practice, and to participate in the blessings of our country, has amounted to 7,000 a year—almost as many as the 7,800 we graduate annually from our own medical schools.

While the primary scientific challenge to medicine is in the advance through research to new truths as rapidly as possible, the great practical challenge has been to bring the role of medicine into the social world of 1968. This is not easy, if for no reasons other than psychological ones—barriers that so commonly separate the man of science and of medicine from the common man. The forces of medicine have tended to remain isolated rather than to be mixed in an intimate way in modern social forces. The training of the physician in medical science, and his relative isolation from the work-a-day world during medical school and the long period in internship and residency training, have significantly influenced his thinking, turning it toward medicine and its problems far more than toward the society in which his patient and he were born and must live and die. One consequence is that often he has failed to recognize the social needs of his patients and particularly those of modern society. He has been deaf to the demands not of his patients but of people as a whole for the benefits which medical science has to offer.

Government Involvement

A few great leaders in medicine saw the signs ahead and recognized the great economic barriers to meeting the medical needs and demands of people; but the politician, the sociologist, and the labor leader long preceded the medical world in answering the demands of people for relief from the economic barriers of health care. Inability to gain access to the services of physicians because of lack of financial resources, inadequate availa-

bility because of maldistribution of physicians, or long delays in getting appointments often have led to great dissatisfaction with the medical profession and with modern medical care.

Medical care is now commonly looked upon as a basic right. So are food, housing, and clothing. But this does not mean that the government should pay for them if the individual or family is able to do so. Where is the logic in the assumption that it is the government's responsibility except for those who cannot afford it for themselves? The growth of voluntary health insurance since World War II has far exceeded that for any other insurance in history, indicating a great need and desire on the part of people to obtain the benefits of modern medicine without economic disaster. It has further led to greater freedom in going to see the physician, in getting into hospitals, in benefiting from elective and optional procedures. Further, it has led to the use of insurance principles on the part of government and payment by government for financial and health care for those for whom it assumes responsibility rather than the direct rendering of such services by the government.

Most research in medicine, in universities and medical schools, is supported by federal funds. The National Institutes of Health, through a variety of types of grants, has done an outstanding job in funding medical research in this country. It continues to do so, and by so doing has been the most significant factor in advancing medical science. But the blessings have not been unmixed because medical schools have become largely research institutions where academic advancement largely depends on research accomplishments and on papers published. Research and teaching have somehow become separated, isolated one from the other, in this process. With acclaim and financial support going in large measure to research the medical faculties devotion to education has atrophied. All too often faculty members are most beholden to the federal government than to the university and medical school. Only recently the pendulum appears to have turned, carrying teaching back toward its rightful position of great strength and respectability; but the full swing will take years.

In the meantime, medical schools have other services and problems piled upon them. Because of the shortage of physicians, there has been great demand for the development of new medical schools and for existing ones to expand to the limit. Five new medical schools opened in this country in the fall of 1967, bringing the total to 94, and another 10 schools are on the drawing boards. The cost of a new medical school is placed at between 50 and 100 million dollars, the operating budget will average 20 million dollars a year, and the cost to a new medical school for each student is in the neighborhood of a half million dollars. Obviously, only the federal government can meet such costs. The problem is to maintain a quality of education that will produce physicians well enough grounded in knowledge and rounded in insight to be able to meet the great challenges and changes in medicine and society that lie ahead.

Medical schools have been challenged even more to assume increasing responsibilities in graduate medical education (internship, residencies and fellowships), and in many institutions there are more in this group in training than in the medical school itself. In addition, medical schools have been increasingly important in the field of continuing medical education—to keep the 250,000 practicing physicians in this country up to date through refresher courses, postgraduate education, and the like. Medical schools must not only operate or supervise large university or affiliated hospitals, they have responsibility for large outpatient clinics and now have been called upon to participate actively in community medicine—to establish centers for health care research to bring medicine to the people. Such models as are now being established may well become those adopted by the medical profession and communities in the future.

Increasingly important in the years ahead will be the people in the allied health professions and services who will play a large part in assisting physicians in one way or another in the health care of the people. More manpower is needed in all categories of health care workers. The education of these people is increasingly becoming the responsibility of high schools, junior colleges, colleges, universities, and professional schools. The integration of them into effective, efficient health care systems is one of the real challenges ahead. So is the development of means by which those who begin at the lower levels of the team's organizational structure can move to their advantage vertically, tangentially, or horizontally after additional education.

The old time beloved physician of the past, while perhaps short on the science of medicine,

was often a master of the art of medicine in the care of the patient and his family. Among the great challenges to the modern physician, with the increasing complexities of medicine and the growth of medical science, is to maintain compassion for and an understanding of his patient—to whom he must bring in the most effective way the best that medicine has to offer. Lord Lytton, years ago, beautifully expressed the symbolism of the role of the physician in this relationship when he wrote:

"To the true physician, there is an inexpressible sanctity in the sick-chamber. At its threshold the more human passions quit their hold on his heart. Love there would be profanation. Even the grief permitted to others he must put aside. He must enter that room in a calm intelligence. He is disabled for his mission if he suffers aught to obscure the keen, quiet glance of his science. Age or youth, beauty or deformity, innocence or guilt merge their distinctions in one common attribute—human suffering appealing to human skill."

The challenges to medicine in society in America are great—stimulating, interesting, and unending. But because of the position of the United States in the world we also have great challenges in international medicine and health. Medicine and science know no international boundaries. The language they speak through the relief of suffering and misery, the control of pain, and the care of the sick and afflicted make the physician the prime ambassador of good will throughout the world. To bring to other nations, and particularly to developing nations, the great blessings and benefits of the art and science of medicine, is a very large and stimulating responsibility. Human hopes are universal and know no international barriers. Medicine and science constitute the best vehicle, the best catalyst to effect an answer to human hopes all over the world—the hopes for good health, for comfort, for freedom from disease, for liberty, and for peace.



FACTORS AFFECTING THE BODY IRON CONTENT:

THEIR RELATIONSHIP TO IRON DEFICIENCY AND IRON OVERLOADING

MARCEL E. CONRAD
LT COLONEL MC

Department of Hematology
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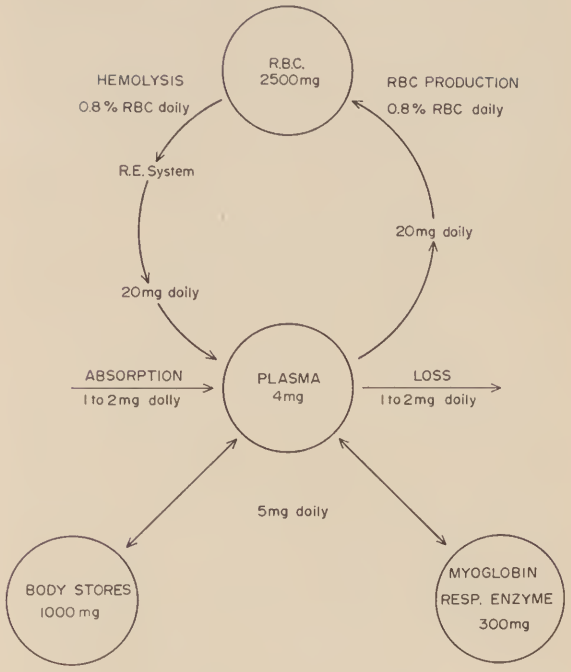
The total body iron in the adult male is about four grams.[1] This quantity of body iron is maintained at relatively constant levels throughout adult life to prevent the development of either iron deficiency or siderosis. This equilibrium is achieved by maintaining a delicate balance between iron absorption and excretion in which absorption plays the more active regulatory role.[2-4]

A fetus accumulates iron from maternal stores throughout pregnancy and has a total body iron content of approximately 250 mg at birth.[5, 6] The newborn infant is fed an iron deficient diet and absorbs little iron during the first few months of life.[7] Subsequently, sufficient dietary iron is absorbed to maintain a body iron concentration of 60 mg per kg and attain a four gram body iron content in adult life.[1] The growing child must absorb an average of 0.5 mg of iron daily in excess of body losses to fulfill these requirements.[8, 9] Contrariwise, the adult preserves a constant level of body iron by efficient conservation of this element, maintaining rigid control over absorption to balance losses. The adult male loses approximately one mg of iron daily, mostly in desquamated epithelium and secretions from the gut and skin.[10-13] During child-bearing years, the normal female loses an additional 30 mg of iron monthly (3 to 80 mg) from menstrual bleeding and about 600 mg with each pregnancy.[14-17] Each of these losses must be balanced by the absorption of an equivalent amount of iron or iron deficiency ensues. On the contrary, the absorption of excessive amounts of dietary iron without compensatory increases in excretion causes siderosis and tissue damage.

Most of the body-iron is present in circulating hemoglobin, a small fraction is incorporated in bone marrow hemoglobin, myoglobin and respiratory enzymes and the remainder is stored in tissues as ferritin or hemosiderin (Fig. 1).[18] Although the body absorbs only 1 to 2 mg of iron daily to maintain equilibrium, the internal requirement for iron is much greater. A red blood cell has a normal lifespan of 120 days so that 0.8% of circulating erythrocytes are destroyed and replaced each day. A human with a 5 liter blood volume has about 2.5 gm of iron incorporated into hemoglobin with a daily turnover of 20 mg of iron for hemoglobin degradation and production and an additional 5 mg of iron for other metabolic requirements.[19, 20] Most of this iron passes through the plasma for utilization. Disordered red blood cell metabolism produces internal derangement of body pools and causes changes in iron kinetics and metabolism. Hemolysis and polycythemia increase hemoglobin production and deplete tissue stores of iron until sufficient additional iron is absorbed to establish a new equilibrium.[20-22] Contrariwise, aplastic anemia and starvation decrease the production of hemoglobin and produce tissue siderosis.[23, 24] Chronic infection and inflammation decrease reutilization of iron from hemolyzed red blood cells; this relative unavailability of degraded heme iron for new hemoglobin production causes a hypoferremic microcytic anemia with iron replete stores.[25, 26]

Although certain disorders can cause marked derangements of iron kinetics within the body, the most important abnormalities of iron depletion and excess must effect either absorption or excretion or both. Thus, any examination of iron equilibrium must include careful scrutiny of the role of the intestinal mucosa. The simplest model of iron absorption must consider (1) the mucosal uptake of dietary iron and (2) the transfer of iron from intestinal cells into the body.[3, 4] It provides three anatomic locations for studying regulatory factors: (a) intraluminal (b) duodenal absorptive cells and (c) corporeal.

Figure 1: Iron Metabolism



Intraluminal Factors

Intraluminal factors affecting iron balance include those anatomic abnormalities, dietary constituents and intestinal secretions which enhance or decrease iron absorption. Adequate quantities of dietary iron must be exposed to the absorptive cells of the gut for a sufficient interval and in a physicochemical form that permits absorption of enough iron to fulfill body requirements. On the contrary, the availability of too much absorbable iron can cause siderosis.[27]

The iron content of the diet is probably the most important intraluminal factor affecting iron absorption. A relatively low incidence of iron deficiency is found in the United States where the adult diet contains 10 to 20 mg of iron. In contrast, the vegetarian diet of Asia contains 5 to 10 mg of iron and is often associated with iron deficiency. However, the problem is more complex; intestinal parasites, chronic infection and protein deficiency may cause or worsen iron deficiency, and a diminished intestinal absorptive surface is commonplace in Asiatic populations.[23, 25, 26, 28-33] Marked differences in the quantity of iron absorbed from various radio-labeled foods attest to the importance of the chemical composition of the diet.[32] Hemoglobin iron is absorbed more efficiently from food than inorganic iron,[34-37] ferrous iron is absorbed in greater quantities than ferric iron[38-39] and dietary constituents which solubilize iron may enhance absorption; whereas compounds that cause precipitation or molecular aggregation of iron decrease absorption.[37, 40-42] We will discuss these factors individually after brief consideration of the biochemistry of iron in aqueous solutions.

In aqueous solutions, metal ions are highly

solvated and are more or less strongly bound to each other through water bridges.[43,44] Increases in pH make more hydroxyl ions available to form metallic polymers or precipitated metallic hydroxides or both. When water molecules surrounding metallic ions are replaced by other molecules or ions, a metal complex or metal coordinating compound is formed. The characteristics of these complexed metallic compounds vary with the chemical structure of the chelator, the redox potential of the metal, the concentration of the substances in solution, the pH, temperature and duration of the solution. The steric location and the number of groups on chelators for combination with metallic ions determine many of the characteristics and physiologic properties of metallic complexes. Ethylenediaminetetraacetate (EDTA) is an ideal sequestering agent for metals with six coordinating bonds; it forms a stable water-soluble iron chelate which inactivates the metal ion and decreases absorption.[45,46] In contrast, the sugars or amino acids have fewer available ligands to bind metals and form less stable complexes that hold iron in solution, even at neutral and weakly alkaline pH. These ligands facilitate the absorption of iron at the alkaline pH of the duodenum by maintaining iron in solution and decreasing polymerization. Certain of these compounds may further enhance iron absorption by being absorbed in combination with the iron.

Metal precipitating agents such as soluble carbonates, oxalates and phosphates combine with metal ions to form insoluble salts which are poorly absorbed.[47] Certain of these anions do not form charged metal complexes but have lattice-building properties which bind anions and metal cations together into a large network. Thus, the combination of iron with the two negative oxygens of carbonate gives rise to a relatively unstable chelate which forms soluble and insoluble complexes of various molecular sizes. The relative amounts of metal ion and ligand often determine whether the product will be soluble or insoluble and in certain combinations the precipitate dissolves in excess precipitating agent.[43,44]

Intraluminal factors which may affect iron absorption are depicted in Figure 2. Many constituents of the diet affect the physicochemical form of dietary iron by either reduction-oxidation reactions or chelation or both. We believe that poor absorption of ferric iron can be attributed to its insolubility at the weakly alkaline pH of the duodenum. The term chelation is confusing because certain compounds that bind iron decrease absorption; whereas, other chelators enhance the absorption of iron from the gut. Food constituents such as the carbonates precipitate iron and form macromolecular aggregates which are poorly absorbed.[42] Conversely, certain amino acids and sugars depolymerize and solubilize iron to enhance absorption.[43,44,48-52] Whereas, some reducing compounds only convert ferric to ferrous iron, other reducing substances act as combinational chelators and reducers; ascorbic acid is a reducing chelator.[53,54] Any discussion of dietary constituents that chelate or reduce iron must consider other factors that influence their role in the gut. A partial listing is: (1) the concentration of the compound in the diet (2) the affinity of the compound for iron (3) the capability of the compound to bind ferric and ferrous iron and heme (4) the effectiveness of chelation at the physicochemical conditions encountered in the intestinal lumen and (5) perhaps the capability of the chelator to be absorbed into the intestinal mucosal cells in chemical combination with iron. Thus, ascorbic acid is a more effective chelator for inorganic iron than fructose or histidine because it binds iron in equimolar concentrations while the sugar and amino acids require approximately a hundredfold greater molar concentration to form a ligand.[48,54] Conversely, histidine binds heme to enhance absorption of heme-iron; whereas, ascorbic acid neither chelates heme-iron nor affects its absorption.[41] Similarly, compounds such as glycine which fail to bind iron at the duodenal pH do not affect absorption.[52]

Gastrointestinal enzymes which release the amino acids or sugars that complex iron from proteins or polysaccharides indirectly affect iron absorption by providing substrate for chelation. Whether intestinal enzymes directly affect iron

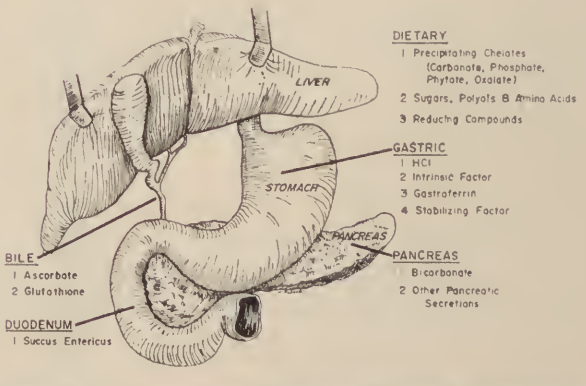


Figure 2: Intraluminal Factors Affecting Absorption

absorption by binding iron is unknown because they have not been individually studied.

Several substances have been identified in gastric juice which either solubilize iron or affect absorption or both. Gastric juice contains a "stabilizing factor" which solubilizes iron at the pH of the duodenum;[29] recent work suggests that this may be either B_{12} binding protein (intrinsic factor)[55] or endogenous ascorbic acid secreted into the stomach.[56] That intrinsic factor can chelate iron is not surprising because of the similarities between iron in the heme molecule and cobalt in vitamin B_{12}. Other investigators have reported a substance in gastric juice (gastroferrin) which binds iron and decreases iron absorption.[57, 58]

Lastly, we will discuss the role of hydrochloric acid, bile and pancreatic secretions in iron absorption. Many investigators have postulated that these secretions affected iron absorption.[59-62] This hypothesis was supported by the development of iron deficiency in gastrectomized humans[63-70] and animals with biliary fistulae[61] and the occurrence of hepatic siderosis in both patients and animals with pancreatic insufficiency.[71-81] However, variable results in iron absorption studies shed doubt upon the validity of earlier observations.[24, 82-85] Certain of these later investigations can be criticized because of the sole use of ferrous salts, the addition of insufficient acid to test doses of iron, or the utilization of test conditions which were not designed to detect decreased absorption of iron. Recent studies showed that gastrectomy and pernicious anemia were associated with decreased absorption of food iron, and that the ingestion of alcohol enhanced the absorption of ferric but not ferrous iron.[69, 86-90]

Dietary iron passes through the acid stomach into the alkaline duodenum for absorption. Gastric juice is sufficiently acid to release iron from foodstuffs and solubilize both ferric and ferrous iron.[43, 44, 89] This permits food iron to form ligands with endogenous and exogenous chelators which may either enhance or decrease iron absorption depending upon their chemical composition. The chemical reaction of ferric salts and chelators such as ascorbic acid, sugars and amino acids is unique in that it must be initiated at an acid pH to insure solubility of the iron at the slightly alkaline pH of the duodenum.[54]

$(FeCl_3 + \text{Ascorbic Acid}) + NaOH \rightarrow \text{Soluble Fe Chelate (pH 8)}$
$(FeCl_3 + NaOH) + \text{Ascorbic Acid} \rightarrow \text{Insoluble Fe Precipitate (pH 8)}$

In this reaction, iron displaces hydrogen ions from ascorbate to form complexes which solubilize iron over a wide range of pH and enhance absorption. In contrast, ferrous chloride combines with ascorbate at the pH of the duodenum making hydrochloric acid less important for enhancement of iron absorption from this compound. These data and the secretion of ascorbate in bile[91] provide an explanation for the development of iron deficiency in gastrectomized humans and the poor absorption of ferric but not ferrous iron in achlorhydric and gastrectomized subjects.

The exocrine pancreas has been shown to play a role in the absorption of iron.[71-81] In laboratory animals destruction of the acinar tissue results in increased iron absorption. Patients with pancreatic insufficiency secondary to chronic pancreatitis or cystic fibrosis have excessive iron absorption and hepatic siderosis. These changes seem related to the secretion of bicarbonate by the pancreas.[42] Bicarbonate causes precipitation of iron and the formation of macromolecular iron aggregates which are poorly absorbed. Further, animal studies show that the stimulation of pancreatic bicarbonate secretion by secretin decreases iron absorption. Although decreased pancreatic secretion of bicarbonate may explain the increased absorption of iron in chronic pancreatitis, cystic fibrosis and perhaps cirrhosis, it is unlikely that it is the sole defect in hemochromatosis since the addition of sodium bicarbonate to test doses of iron significantly affects iron absorption by normal animals but not in iron loaded or iron deficiency states.[42, 62, 71-81]

The capability of iron deficient animals to absorb increased amounts of iron from various iron preparations in the absence of hydrochloric acid or bile or in the presence of added quantities of sodium bicarbonate indicates that these intraluminal factors are less important regulators of iron absorption than the body's requirements for iron. The limited regulation of iron absorption by intraluminal factors provides an explanation for the slow development of iron deficiency in gastrectomized patients, the relatively mild state of iron deficiency observed in achlorhydric subjects and the limited iron overloading that occurs in most patients with pancreatic insufficiency. Gastrectomized patients may become more iron deficient than achlorhydric subjects with pernicious anemia because their anatomic defect decreases the quantity of iron exposed to mucosal cells in the first portion of the duodenum where iron is absorbed best. Perhaps the limited effect of intraluminal factors

upon iron absorption is related to an equilibrium established between small molecular weight iron complexes and macromolecules or precipitate. Iron-loaded subjects would remove little iron from the gut and maintain this equilibrium. Iron deficient subjects would absorb much of the available iron and establish a new equilibrium which provides more monomeric iron in an acceptable form for absorption. Thus, in normal, iron-replete subjects, the physicochemical form of intraluminal iron would have a greater effect upon the quantity of iron which is absorbed.

Mucosal Factors Affecting Absorption

The quantity of iron in the body is maintained primarily by controlled absorption from the duodenum and to a lesser extent by excretion.[2] To maintain balance, the duodenal mucosa must remain attuned to body requirements for iron. Sufficient iron must be absorbed to compensate for losses while available unneeded dietary iron is rejected. Hahn postulated that regulation was accomplished by a mucosal receptor which blocked the absorption of iron when it became satiated with iron.[92] The absorption of poisonous doses of iron indicates that this "mucosal block" can be overwhelmed[27, 93] but does not preclude the existence of a relative block which limits the absorption of excessive dietary iron.[4]

Many investigations of the absorption of iron have been undertaken in humans and animals. Pertinent data has been divided below into ten groups. The first seven describe findings in human studies. The last three are data from animal experimentation that have not been confirmed in man.

1. Generally, iron absorption can be related to the state of repletion of body iron stores. Enhanced absorption occurs with iron deficiency and decreased absorption with iron overloading.[24, 94-96]

2. Factors which stimulate erythropoiesis enhance iron absorption, whereas, diminished absorption occurs with decreased red blood cell production.[94, 96]

3. Although more iron is absorbed from larger doses of iron, the percentage of iron absorbed from larger test doses is increased.[92, 94]

4. Delayed appearance of a portion of oral test doses of iron in fecal collections of normal humans suggest that some of the iron is temporarily sequestered by the gut. This lag in intestinal transit is not observed in iron deficient subjects.[3]

5. Moderate quantities of ferritin are observed in the duodenal mucosal cells of normal subjects. Few particles of ferritin are found in the intestinal epithelium of iron deficient and hemochromatotic humans.[97, 98]

6. Intestinal responses to changes in the size of body stores or the rate of erythropoiesis are delayed. Increased absorption of iron does not occur until three to five days after bleeding.[92, 93, 99]

7. Body iron is lost in the feces in proportion to the state of iron repletion. Iron overloaded subjects can remain in negative iron balance in an attempt to reestablish a normal body iron content. This selective excretion is limited to a few milligrams daily unless bleeding occurs.[10, 100]

8. Iron from body pools can be concentrated in the small intestinal mucosa, where it may act to regulate the entry of dietary iron into the cell. Little dietary iron enters the mucosal cell of iron loaded animals and their duodenal mucosa is iron replete. Contrariwise, iron deficient animals concentrate little iron in their gut and absorb increased amounts of iron. Hypoxia and hemolysis increase iron requirements and cause depletion of intestinal iron with enhanced absorption.[3, 4, 10]

9. If intestinal iron acts to regulate the mucosal uptake of dietary iron, the chemical form of intestinal iron is more important than the total iron content. Starvation decreases the mucosal uptake of dietary iron without a concommitant change in the intestinal iron content. However, more dialysable iron (iron unbound to protein) is concentrated in the mucosa of starved animals than in normal rats.[24]

10. The transfer of iron from intestinal cells into the plasma can be decreased without changes in the mucosal iron content. Endotoxin decreases the absorption of dietary iron without affecting mucosal uptake from the lumen of the gut. Unlike other factors which affect iron absorption, endotoxin reduces absorption within hours after injection.[28]

These data suggest that duodenal absorptive cells act as an iron pool located between the intestinal lumen and the plasma (Fig. 3). The quantity of iron in these mucosal cells remains in equilibrium with labile body iron stores. If iron demands within the body are great, the intestinal

cells are depleted of iron. Contrariwise, if a surplus of body iron exists to meet iron requirements, more iron is incorporated into the mucosal cells. Since these cells are shed into the lumen of the gut at the end of a 2 to 3 day lifespan,[102] this can serve as an effective and selective excretory mechanism. Much circumstantial evidence has been accumulated to indicate that mucosal iron acts as a regulator of absorption.[3, 4, 103-106] Recent information suggests that some chemical forms of cellular iron inhibit mucosal uptake of dietary iron but cellular iron does not affect the transfer of iron from the absorptive cell into the body.[23, 28]

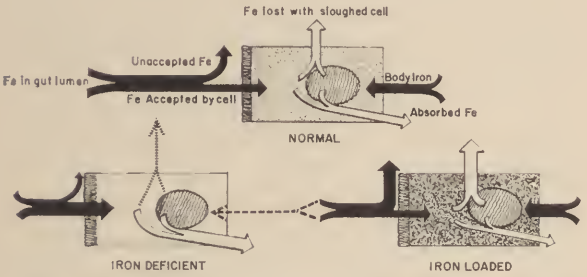


Figure 3: Iron Equilibrium in Intestinal Epithelium

A concept for control of iron absorption by the intestinal mucosa. It is predicated that iron absorption is regulated primarily through the columnar epithelium of the small intestine. In normal, iron-replete subjects the mucosal cells contain a variable amount of iron supplied from body stores. This deposit regulates — within limits — the quantity of iron which enters the cell from the intestinal lumen. Cellular iron may enter the body to meet current body requirements or remain within the epithelial cell to limit absorption and be lost when the cell is sloughed at the end of its lifespan. In iron deficient subjects little iron is retained by the cell because of increased body requirements. Therefore, absorption is enhanced and excretion is diminished. In iron-loaded subjects body iron is incorporated into the mucosal cells in increased quantities to limit absorption and enhance excretion.[3, 4]

Corporeal Factors Affecting Absorption

Two factors are usually cited as important stimuli to iron absorption. These are the rate of erythropoiesis and the tissue iron stores.[29, 30] Accelerated red blood cell production always seems related to enhanced iron absorption whether the cause be bleeding, hemolysis or hypoxia. Conversely, diminished erythropoiesis such as occurs with starvation, blood transfusion or return to sea level from high altitudes decreases the absorption of iron.[93, 96, 99] This makes it tempting to postulate that an erythrocyte stimulating factor acts as a messenger to the gut to increase iron absorption. However, enhanced iron absorption continues in iron deficient subjects long after the hemoglobin mass is restored to normal levels and persists until the body stores become normally replete with iron.[107, 108, 109] In addition, certain cirrhotics and patients with sideroblastic hypochromic anemia have increased iron absorption without accelerated erythropoiesis or depleted iron stores.[110-112] In these patients increased absorption seems related to increased iron turnover. Since accelerated hemoglobin production depletes iron stores, the level of labile iron in tissue stores may be a more basic regulatory factor. If we postulate tissue iron receptors, increased iron absorption would continue until these receptors were satiated and surplus iron would become available for both incorporation into intestinal cells to inhibit absorption and enhance excretion. Thus, idiopathic generalized massive iron overloading (hemochromatosis) would be either a disorder of these tissue receptors or an inability to utilize them properly.

Many investigators have searched for a blood factor which signals the gut to enhance or diminish iron absorption.[113] Careful studies indicate that the hemoglobin concentration and plasma levels of iron and transferrin do not perform these functions.[107, 108, 113, 114] Most factors which affect iron absorption do not exert an effect for several days.[92, 93, 105] That this lag is not caused by the 2 to 3 day lifespan of absorptive cells is suggested by the rapid diminution of iron absorption following an injection of endotoxin and the removal of a hypoxic stimulus.[28, 99] Thus, factors which have a delayed effect upon absorption such as erythropoietin,[115] or pituitary extracts[116] probably influence iron absorption by increasing body iron requirements and not by a direct effect upon the gut.

Several days after blood letting, humans have a transitory decrease in the serum iron concentration and have a sustained increase in the rate of plasma iron turnover. These changes occur simultaneous with the onset of enhanced iron absorption. The rapid iron turnover persists so long as iron absorption is abnormal, but the serum iron concentration returns to normal levels.[105] Animal studies show a similar relationship between increased absorption of iron and a rapid plasma clearance of radioiron in many physiologic situations.[99, 104, 105] However, the administration of endotoxin causes the reverse relationship[28]; decreased absorption of iron and a prolonged plasma iron turnover. Whether this indicates that plasma iron turnover has no etiologic relationship to absorption or that endotoxin causes changes in iron absorption by a different mechanism of action than other physiologic changes is unknown.

Absorption of Porphyrin Iron (Fig. 4)

Separate consideration must be given to the absorption of iron from porphyrins such as myoglobin and hemoglobin. Populations of countries where meat is an important constituent of the diet are usually iron replete, and it has been shown that iron is absorbed from oral doses of hemoglobin in a different manner than inorganic

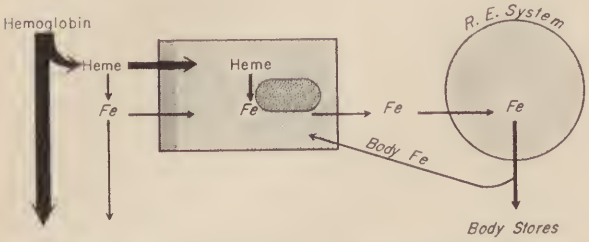


Figure 4: Absorption of Hemoglobin Iron

Schematic diagram of the absorption of hemoglobin-iron. In the duodenum hemoglobin is split by proteolytic enzymes with release of heme and small quantities of iron. Heme enters the intestinal cell as an intact metalloporphyrin. Iron is split from heme within the mucosal epithelial cell before it is transferred into the plasma. If a feedback control regulates the absorption of heme-iron, it must act either by limiting the release of iron from heme within the intestinal cell or by limiting the transfer of iron from the epithelial cell into the plasma or both.[37]

iron. Hemoglobin-iron is absorbed from food more efficiently than inorganic iron and the quantity absorbed is unaffected by the addition of ascorbic acid or iron-binding chelaters.[34-37, 41] Studies of labeled hemoglobin suggest that heme is split from globin by proteolytic enzymes within the duodenal lumen and the heme is absorbed into the intestinal mucosal cells as an intact metalloporphyrin.[37, 41] In humans, the iron is split from heme within the intestinal cell and transferred into the plasma in amounts that are regulated by the body's current requirements for iron.[36, 37] Unlike inorganic iron, heme is soluble in alkaline media and not in acid.[41] Thus, the duodenal pH is more advantageous for heme solutions than for iron salts. In solution, heme molecules have lattice building qualities and bind with each other to form macromolecular polymers that are poorly absorbed. Enzymatic breakdown of globin into amino acids in the duodenum enhances the absorption of heme because primary amines coordinate with the heme to maintain it as a small molecule in a monomeric state.[34, 45, 46] Similarly, the addition of amino acids or amides to the diet increases absorption by decreasing precipitation and polymerization of the metalloporphyrin within the intestinal lumen.

Iron Excretion

Previously, it was believed that the quantity of iron in the body was controlled by regulated absorption and that excretion played a passive role.[2] However, most cells contain iron somewhat in proportion to the quantity of iron in body stores. Thus the daily obligatory loss of cells from the skin and gut, and secretions such as bile, sweat and sebum provides a limited but selective loss of body iron.[4, 10-13, 100, 104] In addition, there is a normal daily fecal loss of about 0.7 ml of blood (0.4 mg of iron).[117] Excretion studies show that iron loaded animals lose more body iron than normal animals and iron deficient animals lose less. In humans, approximately one-third of body iron losses occur in the feces and two-thirds are lost from the skin.[11, 13] Usually, little iron is excreted in the urine (0.1 mg per day). However, sustained intravascular hemolysis can cause urinary iron losses that produce iron deficiency (10 mg per day).[118, 119] In normal iron replete humans losses are balanced by the absorption of dietary iron (1 to 2 mg daily). In transfusional siderosis daily excretion of iron exceeds absorption by about 4 mg in an attempt to reestablish the normal body iron content.[100] Comparison of acute and chronic studies of iron excretion shows that recently administered iron is lost in greater quantities than iron which has been incorporated into hemoglobin or body stores.[11, 13]

Iron Deficiency

Iron deficiency must be defined as a reduction of total body iron below normal levels. Arbitrarily, iron deficiency may be classified as mild, moderate and severe. Mild iron deficiency exists when the total body iron is reduced, but there is sufficient iron to provide a normal mass of hemoglobin. This may be detected by serum iron determinations or iron stains of biopsy specimens from the bone marrow or liver. Hemoglobin has a high priority for body iron and the iron stores will be depleted to maintain the hemoglobin concentrations.[107, 108, 120] The term iron deficiency anemia is properly used to describe moderate and severe iron deficiency because there is insufficient iron to make normal quantities of hemoglobin. It can be distinguished from other causes of anemia by demonstration of a decreased serum iron concentration; an elevated total iron binding capacity, and depleted iron stores in individuals with a microcytic hypochromic anemia.[121, 122] Unless there is an obvious cause of iron deficiency each of

these parameters should be tested to insure the establishment of a correct diagnosis. The physician's diagnostic responsibility does not end with the proper establishment of a diagnosis of iron deficiency—a cause for the decrement in body iron must be sought. Otherwise, therapeutic administration of iron may correct the anemia and delay detection of a bleeding cancer. Severe iron deficiency is manifested by a symptomatic anemia. Shortness of breath and a rapid pulse with mild exertion occur when the hemoglobin concentration is less than 7 g/100 ml. At these hemoglobin concentrations, the decreased oxygen carrying capacity of blood is complicated by hemoconcentration.[123] In addition, the circulating blood contains many minute and deformed red blood cells with a shortened lifespan which worsens the anemia.[31, 124]

Etiology of Iron Deficiency (Table I)

In countries where the diet is iron replete, iron deficiency must be considered "prima facie" evidence of bleeding until another cause is demonstrated. The physician who treats iron deficiency assumes responsibility to investigate patients for the underlying etiology lest he overlook a curable neoplasm. Blood loss is usually detected by the patient because of the intense pigmentation of hemoglobin unless it occurs as a result of (1) surgery or obstetric delivery, (2) excessive menses or (3) gastrointestinal bleeding. The surgeon frequently underestimates blood loss and women believe their menstrual loss is "normal" unless it is unlike previous periods. Intestinal hemorrhage can remain occult because hemoglobin is degraded by bacteria within the bowel and loses its characteristic appearance. Chemical analyses or radioisotopic techniques are usually necessary to show that blood is (or is not) in feces. Although the causes of gastrointestinal hemorrhage are extensively reviewed elsewhere, they deserve brief comment. Bleeding can be caused by intrinsic lesions of the bowel wall, intestinal parasites or a coagulation defect. Intestinal lesions may be benign or malignant. Endoscopic examinations and roentgenographic studies using contrast media are usually necessary to locate the lesion and establish a diagnosis. Surgical excision and pathologic examination may be required to ascertain whether the lesion is benign or malignant. Feces from every patient with iron deficiency should be examined for parasites. Hookworm infestation is prevalent and can cause severe anemia.[131] A single necator americanus bleeds man 0.1 ml daily, whereas, an ancylostoma duodenale causes twice this blood loss. Lastly, patients with thrombocytopenia lose small quantities of blood in their feces each day to become iron deficient if the disease persists for several months.

TABLE I

FACTORS RELATED TO IRON DEFICIENCY

1. Hemorrhage
   a. Benign and malignant lesions
   b. Trauma
   c. Intestinal parasites
   d. Coagulation defects
2. Malabsorptive Disorders
   a. Gastric
   b. Small intestinal
3. Dietary Factors
   a. Iron content of diet
   b. Composition of diet
   c. Protein deprivation
4. Inflammation and Infection
5. Increased Iron Requirement
   a. Growth
   b. Pregnancy

Patients with small intestinal malabsorptive disorders such as sprue have decreased absorption of iron.[125] It is postulated that this is caused by a loss of absorptive surface; the small intestine loses its characteristic villous appearance to become flattened and atrophic.[126,127] This may have added importance because the intestinal histology of normal Asians shows broadened and flattened villi which would decrease the surface area for absorption and may contribute to the incidence of iron deficiency in that geographic area.[33]

Gastrectomy and atrophic gastritis decrease iron absorption and can produce iron deficiency.[128] This seems to be caused by an inability to release ferric iron from food and permit this iron to chelate with endogenous and exogenous iron chelates which solubilize ferric iron so that it can be absorbed from the alkaline duodenum.[54]

In adult men and post menopausal women nutritional factors are rarely the sole cause of iron deficiency anemia. Iron losses are selectively limited and iron stores are sufficiently large to maintain enough body iron for prolonged periods of dietary deprivation. Contrariwise, the requirements of growing children and menstruating or pregnant females place them in a precarious state of iron balance so that a poor diet can rapidly lead to the production of iron deficiency anemia.[32] In children and young women the iron content and composition of the diet are important factors in the prevention of iron deficiency. A relatively low incidence of iron deficiency is found in the United

States where the adult diet contains meat and 10 to 15 mg of iron. In contrast, the vegetarian diet of Asia contains 5 to 8 mg of iron and is often associated with iron deficiency. In addition to the quantity of iron in the diet, the chemical form of the iron and various ingredients in the diet seem to play a role in the regulation of absorption.[29, 30, 32, 37, 41, 42] Consideration of these factors seems to provide the American diet with an additional advantage for maintaining iron balance.

Recent animal experimentation suggests that infection and protein depletion decreases the absorption of iron.[23, 28] In various studies of infections, acute processes cause decreased absorption, while equivocal changes are observed in chronic disease.[129-131] This may indicate that absorption is reduced until a new body equilibrium is established and then measurements of iron absorption become normal with a moderate reduction in the body iron content.[23] If similar changes occur in humans these factors would provide additional causes for iron deficiency in the underprivileged areas of the world.

Clinical Manifestations of Iron Deficiency

The symptoms of iron deficiency are nonspecific and often overlooked or attributed to psychogenic causes. The common complaints are fatigue, weakness, headache, dizziness, exertional dyspnea, palpitation, parasthesias, loss of libido and mild gastrointestinal symptoms.[132-135] They cannot be attributed solely to anemia because they occur in iron deficient subjects whose hemoglobin concentration is within the range of normal values. It is postulated that they are caused by a decrement of other essential iron containing compounds, such as the respiratory enzymes.[136-140] These enzymatic deficiencies may explain the changes occasionally observed in other organs such as the fingernails (koilonychia), tongue (papillary atrophy), esophagous (sideropenic dysphagia),[141] stomach (gastric atrophy),[142] skin (edematous depigmentation),[143] brain (pseudotumor with papilledema),[144] bones (roentgenographic changes, dwarfism)[145-146] and gonads (hypogonadism)[146] of certain iron deficient patients in various geographic areas. The spleen may become palpable in patients with simple iron deficiency anemia. In our experience, splenomegaly is only associated with moderately severe or prolonged iron deficiency unless it is a manifestation of another underlying disease.

A careful history for bleeding must be sought from every iron deficient patient. Blood loss from the hemorrhoids and menses is usually underestimated and the significance of tarry stools is not known by most patients. A geographical history can provide clues to dietary habits and parasitemia. The protein content of the diet is important and each patient should be specifically questioned to ascertain if they eat laundry starch or clay.[147-148] These latter dietary idiosyncrasies are often associated with severe iron deficiency.

Laboratory Tests of Iron Deficiency

Laboratory findings depend upon both the severity and duration of iron deficiency. The most useful techniques for establishing a diagnosis of iron deficiency are examination of red blood cells, measurement of the serum iron concentration and total iron binding capacity and estimation of the quantity of iron in bone marrow specimens. In moderate or severe chronic iron deficiency each of these tests is abnormal; erythrocytes are microcytic and hypochromic, serum iron levels are decreased, iron-binding protein values are elevated and bone marrow specimens contain no stainable iron. However, abnormalities in each test depend upon the (1) severity, (2) rate of induction and (3) duration of iron deficiency because (a) tissue stores are depleted to maintain the hemoglobin concentration (b) circulating red blood cells have a normal lifespan of 120 days and (c) certain body iron stores are mobilized slowly. This is exemplified by observations in humans who were made iron deficient by blood letting (Fig. 5 and 6).[108] Thus, in mild chronic iron deficiency the tissue stores are reduced or depleted at a time when the red cell morphology and plasma iron and transferrin measurements are normal. Contrariwise, immediately following acute blood loss, plasma iron determinations are a more sensitive indicator of iron deficiency than either the red cell morphology or iron stains of bone marrow specimens. Red blood cell indices are less reliable than examination of erythrocyte morphology because they are a mean value which fail to detect a double population of red blood cells. In the experiment illustrated by Fig. 5 and 6 the cellular indices remained within the range of normal values for 60 to 80 days after phlebotomy but stained smears of the peripheral blood showed a dimorphic population of red cells; older normal circulating cells produced before the induction of iron deficiency and younger microcytic hypochromic erythrocytes that reflected an iron deficient state.

Each of these laboratory tests is subject to experimental error. In addition to technical competence, accurate measurements of the serum iron and total iron binding capacity are dependent upon the preparation of iron-free reagents and glassware. The red blood cell indices are calculated from measurements of the hematocrit, hemoglobin concentration and red blood cell count. Inadequate mixing of blood before withdrawal of an aliquot for measurement is a common source of error for each of these tests. Poorly calibrated pipettes can cause significant errors in both the hemoglobin concentration and red blood cell count. Failure to enumerate less than 2000 erythrocytes in counting chambers produces errors greater than 5%. If bone marrow aspirates are used, careful preparatory techniques are needed to avoid excessive dilution of the smear with peripheral blood. If bone marrow biopsy specimens are prepared, the initial fixation should be performed at a neutral pH or iron is leached from the specimen. Even examinations of the red blood cells in a stained smear of peripheral blood are subject to marked variability of interpretation by different individuals.[120-122] Thus, a combination of these laboratory methods should be used to evaluate any suspected case of iron deficiency.

Ferrokinetic studies permit measurements of iron absorption and excretion, the rate of clearance of transferrin bound iron from the plasma and calculation of the body iron turnover and quantification of the percentage of an intravenous dose of transferrin-iron or hemoglobin-iron that is reutilized for synthesis of circulating hemo-

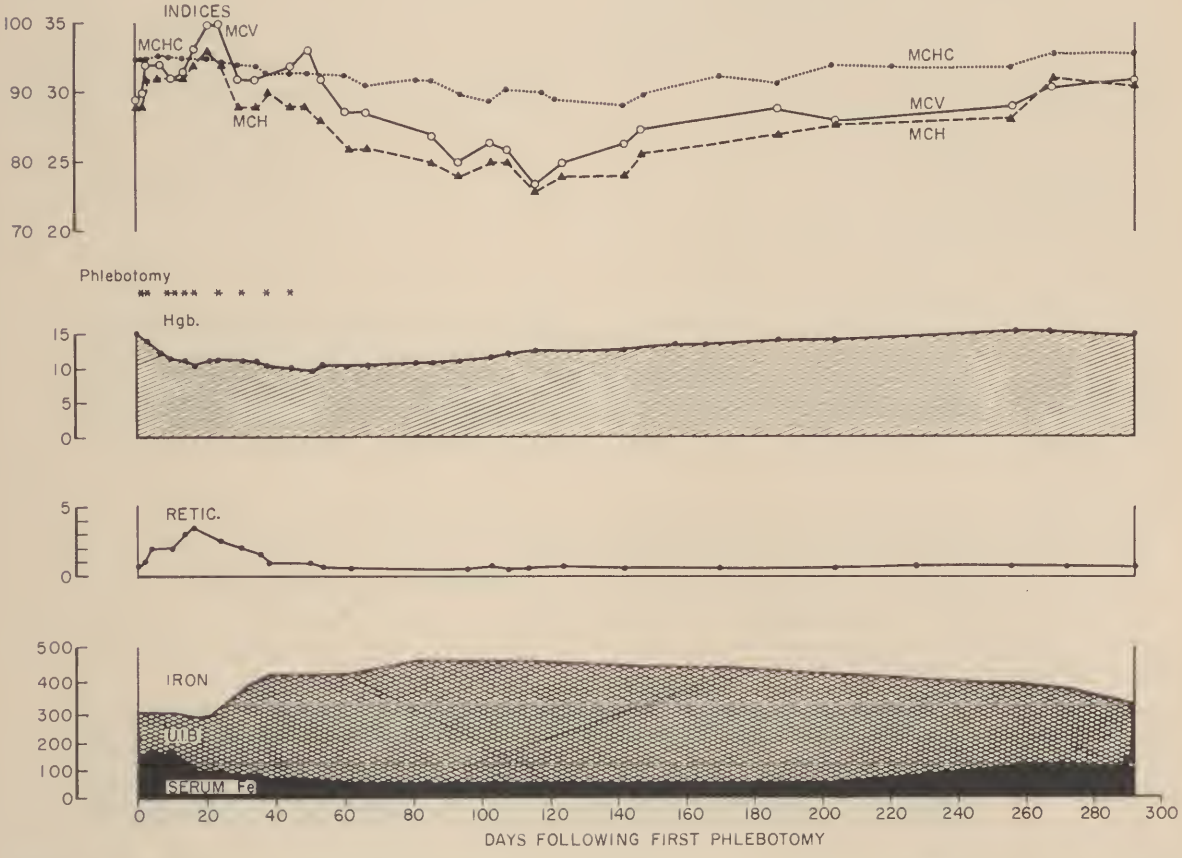


Figure 5: The effect of blood letting upon various laboratory tests for iron deficiency is illustrated above. Each asterisk represents a phlebotomy of 500 ml of blood (0.2 grams of iron). The hemoglobin concentration decreases in response to bleeding. Reticulocytosis occurs because of increased production of red blood cells but cannot be sustained after body stores are depleted of iron. The decreased serum iron concentration is the earliest evidence of iron depletion and is followed by a pronounced increase in the total iron binding capacity. These changes persisted until the hemoglobin concentration returned to normal prephlebotomy values. Examination of the cellular erythrocytic indices shows an increase in the mean corpuscular volume (MCV) 10 to 20 days after the initiation of phlebotomy, coinciding with the reticulocyte response. Then the cells gradually decreased in size but did not reach values below the normal range until 80 days after the bleeding was initiated. At 280 days blood values had returned to prephlebotomy levels. However, the bone marrow was depleted of stainable iron and iron absorption remained markedly increased.[29]

globin.[29, 30] Although much information has been learned from radioisotopic studies of iron metabolism, these tests are not practical methods for establishing the diagnosis of iron deficiency by the general medical practitioner. Each of these studies are time consuming and require special laboratory facilities and equipment.

Finally, the diagnosis of iron deficiency can be evaluated by a response to the administration of iron. Following the initiation of iron therapy, ing repeated doses of parenteral iron preparations,[150-153] (3) responsiveness to parenteral iron but not oral iron therapy can be used to diagnose malabsorption and (4) oral iron is less expensive than parenteral preparations. If a patient fails to respond to iron therapy or responds poorly, data supporting the diagnosis of iron deficiency must be carefully reevaluated. In geographic areas with poor nutrition combinational deficiencies of iron, folic acid and vitamin B_{12} are fre-

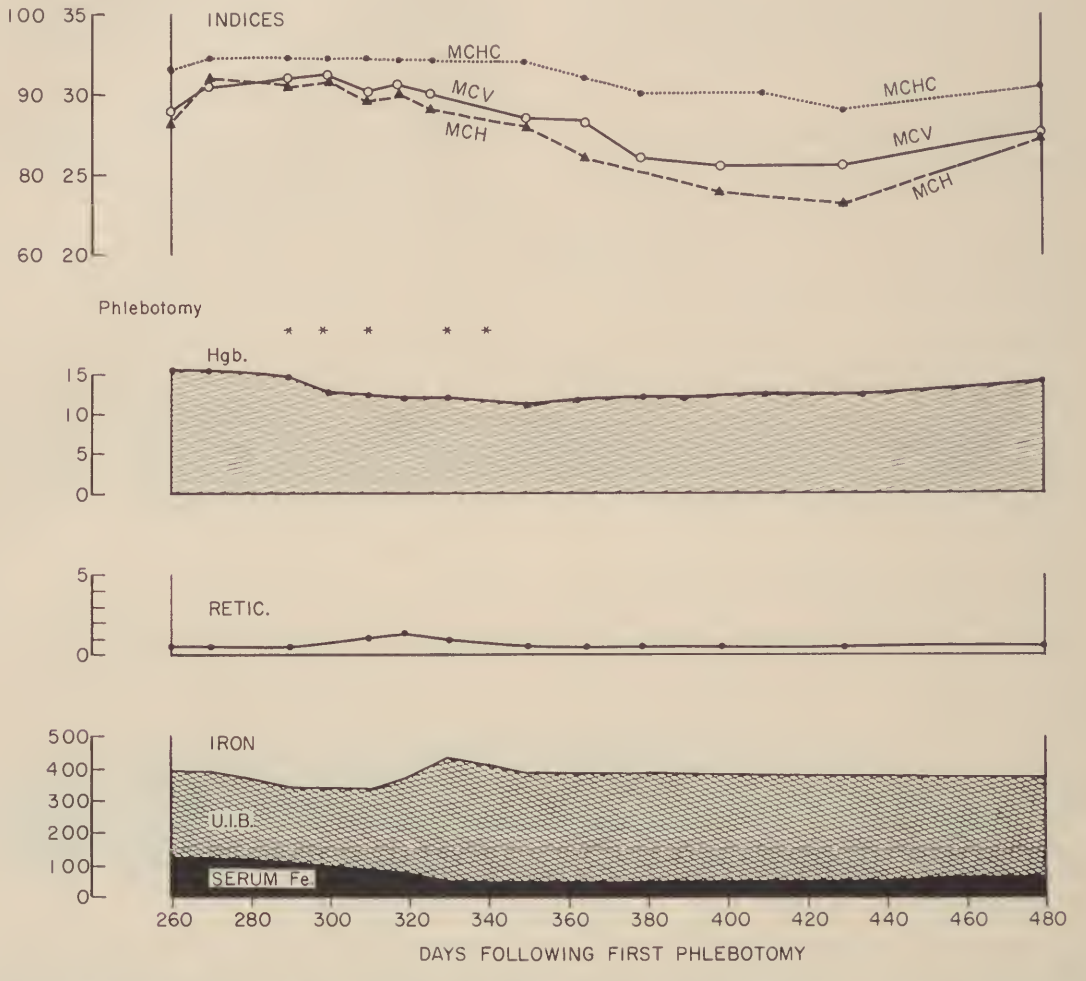


Figure 6: The subject of Figure 5 was bled an additional 2.5 liters of blood after recovery from abnormalities in the peripheral blood suggestive of iron deficiency. The lack of available iron in tissue stores prohibited the development of reticulocytosis in response to bleeding. Studies of the period required for repletion of the hemoglobin mass of this subject indicated he absorbed about 6 mg of iron from an American diet (15 mg of iron) daily.[29]

patients with iron deficiency anemia will develop reticulocytosis within 5 to 14 days. Subsequently, a rise in the blood hemoglobin concentration can be detected. A trial of oral iron should be utilized before resorting to parenteral iron preparations because (1) the rate of response is similar,[149] (2) serious reactions occasionally occur frequent.[154] These patients respond partially to treatment with one therapeutic agent and the hemoglobin concentration reaches a level below normal values. If iron is the initial therapy, the anemia becomes more macrocytic, whereas if folates or B_{12} are used microcytosis and hypochromia become marked. In parts of the world where nutri-

tion is adequate other causes for a retractory microcytic hypochromic anemia are more frequently encountered (Table II).

Generally, the iron-overloaded hypochromic anemias can be distinguished from iron deficiency by the elevated serum iron concentration and increased iron in tissue stores. Chronic infection, inflammatory diseases and neoplasia may cause a microcytic hypochromic anemia and hypoferremia because of an impaired capability to reutilize hemoglobin iron for the synthesis of hemoglobin.[25, 155] However, tissue stores usually contain stainable iron and the total iron binding capacity is decreased rather than elevated. Patients with pulmonary siderosis show evidence of iron deficiency because the lungs sequester excessive quantities of iron at the expense of the remainder of the body.[156] The diagnosis must be established by roentgenographic findings and demonstration of iron in expectorated pulmonary cells.

Iron Overloading Disorders

The terms *hemochromatosis* and *hemosiderosis* are misnomers which have added confusion rather than exposition to the iron overloading disorders. The iron overloading disorders should be classified into an *idiopathic* variety in which the basic etiology is unknown and a *secondary* group associated with other diseases which cause iron deposition in various portions of the body (Table III and IV). In many of these disorders quantitative measurements of the iron overloading occurs if the quantity of iron entering the body consistently exceeds loss. In contrast, relative or focal siderosis can result from redistribution of body iron. Thus an elevated serum iron concentration and siderosis of one body organ are insufficient to establish a diagnosis of generalized massive iron overloading. The generalized distribution of excessive body iron should be demonstrated by stains of biopsy specimens and multiple organs such as the skin, stomach, small intestine, bone marrow and liver. The massive nature of the iron overload can be quantified by bleeding the patient until he becomes iron deficient; phlebotomy of 500 ml of blood with a normal hemoglobin concentration (15 g/100 ml) depletes the body of 250 mg of iron (1 g hemoglobin contains 3.4 mg iron).[157]

Every patient with suspected iron overloading should be questioned about previous parenteral iron therapy and blood transfusions and for a family history of anemia, diabetes, cirrhosis or cardiac insufficiency. Blood relatives should be examined for anemia and evidence of iron storage disease. The blood of both the patient and his family should be tested for hyperferremia and the presence or absence of microcytic hypochromic erythrocytes.

Idiopathic, generalized massive iron overloading (hemochromatosis)[100, 158-168] is a familial disorder in which excessive amounts of dietary iron are absorbed and accumulate in various organs of the body to produce tissue damage. Usually, the disease becomes manifest during the fourth to sixth decades of life as cirrhosis, diabetes mellitus, heart failure or pigmentation of the skin. Hemochromatosis should be suspected in patients with any

	Genetic	Hemolytic	Serum Iron	TIBC	Iron Store	RBC FE Incorporated	Special Tests
Iron Deficiency Mild - Moderate Severe		 o +	↓	↑	o	↑	
Inflammation		o/+	↓	↓	+ +	FE ↑ HB-FE ↓	
Pulm. Hemosiderosis		o	↓	↑	o	↓	Stain Sputa for Fe
Thalassemia Major Minor	Congenital	 + + + + + +	 ↑ N/↑	 N N	 + + + + +	Delayed	A_2 and Fetal Hb
Pyridoxine Responsive	Delayed Expression	o	↑	N	+ + +	↓	Response to Therapy
Idiopathic Sideroblastic	Sex-Linked Delayed	o	↑	N	+ + + +	↓	No Response to Pyridoxine

Table II. Microcytic Hypochromic Anemias

of these findings and considered probable if two or more of this tetrad coexist. This probability is supported by an elevated serum iron which almost completely saturates the total iron binding capacity. However, the diagnosis cannot be established with certainty until the massive and generalized nature of the iron overload are demonstrated in patients with normocytic red blood cells who have no history of multiple blood transfusions or prolonged and excessive dietary intake of iron. Although the generalized nature of the iron overload can be established by examination of stained biopsy sections from multiple organs, we believe iron stains of small intestinal biopsy specimens provide the most reliable information. The lamina propria of the duodenum and jejunum do not contain excessive deposits of stainable iron until the patient has a 10 g body store. Excessive deposits of iron in the skin and gastric mucosa can be found following a hematoma or gastritis. The bone marrow contains relatively little iron in idiopathic hemochromatosis, and the liver shows excessive deposits of iron in certain patients with Laennec's cirrhosis. Massiveness of iron overloading is demonstrated by tolerance to repeated phlebotomy; normal subjects develop iron deficiency anemia following a loss of 2 to 3 liters of blood, whereas, most hemochromatotics tolerate a 50 to 100 liter blood loss before they develop a sustained anemia with hypoferremia and depletion of iron from their tissue stores. Energetic phlebotomy should be undertaken to reduce excessive deposits in organs of the body and prevent further tissue damage. In hemochromatotics under 40 years of age, blood letting should be considered a medical emergency because of the frequency of sudden death from cardiac arrhythmias. In older patients the disease usually becomes manifest as cirrhosis, diabetes or congestive heart failure.

TABLE III
IRON-OVERLOADING DISORDERS

1. **Idiopathic Generalized Massive Iron Overloading (Hemochromatosis)**
2. **Secondary Iron Overloading (Hemosiderosis)**
   - **A. Generalized and Massive**
     - **(1) Blood transfusion siderosis**
     - **(2) Parenteral administration of excess iron**
     - **(3) Excessive prolonged dietary intake (Bantu, Kaschin-Beck)**
     - **(4) Associated with microcytic hypochromic anemia**
       - **(a) Thalassemia major**
       - **(b) Pyridoxine responsive anemia**
       - **(c) Sex-linked sideroblastic hypochromic anemia**
   - **B. Relative or Limited**
     - **(1) Polycythemia, primary and secondary**
     - **(2) Hemolytic disorders**
     - **(3) Aplastic anemia**
     - **(4) Pancreatic insufficiency**
   - **C. Focal**
     - **(1) Renal (intravascular hemolysis)**
     - **(2) Pulmonary (pulmonary hemosiderosis)**
     - **(3) Hepatic (sideroblastic Laennec's cirrhosis)**

Table IV: Manifestations of Disorders Associated with Abnormal Iron Storage

	Genetics	Clinical Manifestations: Cirrhosis	Diabetes	Cardiac	Serum Iron	Tot Iron Binding Capacity	Tissue Iron Stores: Liver	Bone Marrow	Skin & Gut	Red Blood Cells	Hemolysis	RBC Radioiron Incorporation	Comments
Idiopathic Hemochromatosis	Delayed Expression	+ + + +	+ + +	+ +	↑ ↑ ↑ ↑	N	+ + + +	+ +	+ + + +		(2)	↓ ↓	
Transfusional Siderosis		±	±	±	↑ ↑ ↑ ↑	N	+ + + +	+ + + +	+ + + +	(1)	(1)	↓ ↓	History of massive transfusions
Prolonged Dietary Intake													
Bantu	Tribal	+ + +	±	±	↑ ↑ ↑ ↑	↓	+ + + +	+ + + +	+ + + +		0	↓ ↓	
Kaschin Beck	Geographic	±	?	?	↑ ↑ ↑ ↑	↓	+ + + +	+ + + +	+ + + +		0	?	Polyarthritis & bone deformity
Thalassemia Major	Congenital	+	+	+ + + +	↑ ↑ ↑ ↑	N	+ + + +	+ + + +	+ + + +	Micro. Hypochr.	+ + + +	↓ ↓ ↓	Retarded growth Abn. fetal Hb
Pyridoxine Resp. Anemia	Delayed Expression	+	+	+ +	↑ ↑ ↑ ↑	N	+ + + +	+ + +	+ + + +	Micro. Hypochr.	0	↓ ↓ ↓	Response to pyridoxine
Sex linked Hypochromic Anemia	Delayed Expression	+	+	+ +	↑ ↑ ↑ ↑	N	+ + + +	+ + +	+ + + +	Micro. Hypochr.	0	↓ ↓ ↓	No response to pyridoxine
Polycythemia		0	0	0	↓ ↓	↑ ↑	0	0	0	Mild Micro.	0	N	Elevated Hb & RBC mass
Hereditory Spherocytosis	Congenital	0	0	0	↑	N	+ +	+	0	Spherocytes	+ + +	↓	
Aplastic Anemia		0	0	0	↓ ↓	N–↓	+ + +	+ +	0	Mild Macro.	+	↓ ↓ ↓	
Renal Siderosis		0	0	0	↓ ↓	↑	0	0	0	Mild Micro.	+ + + +	↓	Urinary hemosiderin plasma Hb & haptoglobin
Pulmonary Siderosis		0	0	0	↓ ↓	↑	0	0	0	Mild Micro.	0	↓	Sputa for Fe
Sideroblastic Cirrhosis		+ + ↑ ↑	±	0	↑ ↑ ↑	N–↓	+ + + +	+ + +	0		(2)	N	

(1) Dependent upon underlying etiology (2) Hypersplenism may be present.

Most hemochromatotics tolerate blood letting at a rate of 2 or 3 pints weekly. This can be continued until the labile stores have been depleted and then a slower rate of blood letting must be utilized. The period of vigorous phlebotomy usually removes about three fourths of excessive iron deposits. Depletion of this readily available iron pool can be detected by the inability to maintain the hemoglobin concentration, the development of reticulocytopenia and depression of the serum iron concentration with continued blood letting. However, excessive quantities of iron are found in tissue specimens and cessation of phlebotomy is followed by a rapid return of the hemoglobin concentration and serum iron to prephlebotomy values. Continued blood letting at a slower rate permits depletion of the less easily mobilized iron stores. Once this occurs a more prolonged period of iron deficiency ensues and the liver and bone marrow contain no stainable iron. Certain investigators have questioned the efficacy of blood letting in the treatment of idiopathic hemochromatosis. However, untreated hemochromatotics have a progressive downhill course with death caused by cirrhosis, hepatic carcinoma, diabetes mellitus or cardiac dysfunction. Conversely, removal of excess iron by energetic phlebotomy produces marked improvement in hepatic, pancreatic and cardiac function within months after its induction and eventual disappearance of histologic evidence of cirrhosis. Iron stores should be maintained at near normal levels for the remainder of the patient's life. Once excessive stores have been depleted this can usually be accomplished by quarterly donations of a pint of blood. The biochemical lesion causing idiopathic hemochromatosis has not been identified. Studies of the rate of repletion of iron stores by hemochromatotics indicate that these patients accumulate approximately 3 mg of iron each day. Thus, the basic defect of this disease causes increased absorption of iron and decreased excretion until a massive store is accumulated. Whether the defect is a generalized abnormality of epithelial cells or a relative inability to mobilize stored iron is unknown.

The secondary iron overloading disorders should be classified into a group in which there is generalized massive siderosis and diseases which are associated with relative, limited or focal iron overloading. Secondary generalized massive iron overloading occurs following multiple blood transfusion, the injection of excessive quantities of iron, prolonged excessive dietary intake of iron and associated with microcytic hypochromic anemias in which there is a defect in hemoglobin synthesis. Blood transfusion is an important cause of siderosis because each pint of blood contains 250 mg of iron and maximal body excretion is limited to a net loss of about 4 mg daily.[100, 157] The Bantus have marked tissue siderosis from the ingestion of a diet that contains much iron and alcohol,[169] and in Manchuria generalized siderosis with polyarthritis occurs from an iron overloaded water supply. Patients with thalassemia major developed massive generalized siderosis, and this is worsened by repeated transfusions of these patients for their anemia.[170, 171] Cardiac arrhythmias are a frequent cause of death from this disease due to myocardial deposition of iron. The severity of anemia usually prohibits the use of repeated phlebotomy to lessen the iron overload. Parenteral administration of iron chelaters have been advocated to deplete the excess iron stores of patients with thalassemia major. The results of large long term studies are needed to ascertain if this relatively inefficient method of ridding the body of iron is worthwhile in the treatment of thalassemic patients. Usually these patients are easily identified because of their retarded growth skeletal abnormalities and a hemolytic anemia with microcytic hypochromic red blood cells. Studies of the parents show thalassemia minor; the trait is unassociated with massive iron overloading because these patients can increase excretory losses to balance their excessive absorption of iron.[172] Pyrodoxine responsive anemia and a sex-linked hypochromic anemia are associated with a massive generalized iron overload.[111, 112, 173] Unlike thalassemia these patients do not have evident physical deformity because the disease does not become manifest until adult life. These disorders are characterized by a microcytic hypochromic anemia without hemolysis, ineffective utilization of iron for hemoglobin synthesis, an elevated serum iron and tissue siderosis. In one group of patients, large doses of pyrodoxine improve the anemia and increase the incorporation of iron into hemoglobin. The presence of anemia usually brings these patients to the physician before marked tissue fibrosis occurs. However, pathological changes similar to idiopathic hemochromatosis can occur and have been reported to cause death. Patients with pyrodoxine responsive anemia and sex-linked hypochromic anemia usually tolerate phlebotomy at a rate of one pint of blood weekly. Blood relatives should be examined for evidence of the disease so that excessive iron can be removed by

phlebotomy before tissue damage occurs.

Relative, limited or focal siderosis produce insignificant changes in the total body iron but marked alteration in the distribution of iron within the body. Limited iron loading is found in polycythemia and many hemolytic disorders because increased absorption of iron occurs in response to accelerated production of hemoglobin. However, once body requirements are satiated, losses keep pace with absorption to prevent accumulation of a massive store. In aplastic anemia, much of the heme-iron from destroyed red blood cells is not reutilized for hemoglobin synthesis. This excess iron is deposited in body stores to cause tissue siderosis without significant change in the total body iron content. Patients with pancreatic insufficiency secondary to chronic pancreatitis or cystic fibrosis develop moderate and limited hepatic siderosis from increased iron absorption. This is probably caused by the absence of pancreatic secretions such as bicarbonate which precipitate and polymerize iron to reduce absorption from the lumen of the gut.[42, 77] In certain disorders increased amounts of stainable iron are deposited in a solitary organ without an increase in the iron content of other body tissues. This occurs in the kidneys of patients following intravascular hemolysis,[174] the lungs in pulmonary hemosiderosis,[175] and in the liver of certain patients with Laennec's cirrhosis. Patients with Laennec's cirrhosis and limited or focal siderosis may be difficult to distinguish from other patients with diseases in which there is massive generalized iron overloading. The liver of certain cirrhotics contains large quantities of stainable iron. In addition, the serum iron may be markedly elevated with a bone marrow that contains many sideroblasts. However, biopsy specimens from other organs such as the skin, the stomach or the small intestine show normal quantities of stainable iron, indicating that the iron overload is not generalized. That the iron store is not massive can be shown by bleeding these cirrhotics until they become iron deficient and their liver is depleted of stainable iron; usually iron deficiency is induced by phlebotomy of 10 pints of blood. The etiology of these findings of focal iron overloading in certain cirrhotics is worthy of comment. Many red blood cells containing siderin particles are produced by the bone marrow of these patients. Shortly after these cells are delivered into circulation, the spleen removes the siderin from intact erythrocytes to cause accelerated iron turnover and an elevated plasma iron concentration with excessive deposition of iron in the liver.[110, 176]

The other forms of focal siderosis are usually not confused with generalized massive iron overloading. Renal siderosis is caused by hemoglobinemia and pulmonary siderosis occurs from bleeding into the lung. Sequestration of iron in the kidney or the lung and loss of iron in the urine or sputum depletes other tissues of iron and cause changes suggestive of iron deficiency rather than iron overloading.

Summary

Body-iron is maintained by a delicate balance between absorption and excretion in which absorption plays a more active regulatory role. The intraluminal, mucosal and corporeal factors affecting the absorption of ferrous, ferric and hemoglobin iron in normal and various disease states were discussed. Limited but selective excretion of iron occurs from the gut and skin; it attempts to reestablish a normal body-iron content following therapy with excessive parenteral iron and in hemolytic disorders with enhanced iron absorption. The etiology, investigation and treatment of patients with iron deficiency and iron-overloading were described. The pathophysiology of abnormal states of iron repletion was discussed and related to factors which affect the body iron content.

A list of references will be supplied upon request.



SOME APPARENTLY COMMON PROBLEMS IN PATIENTS RECEIVING CONTRACEPTIVE PILLS

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This article is in the nature of a warning to physicians prescribing the so-called contraceptive pills whether for the purposes of pregnancy prevention or for the treatment of gynecologic disorders including dysmenorrhea, endometriosis, dysfunctional uterine bleeding, menstrual irregularity, etc.

It is felt that the side effects of depressive symptoms and also malaise, fatigue, tension, lack of libido and acceleration of vascular type headaches during administration of these pills is a more frequent problem than believed by most physicians. This article is based on an unscientific sampling of some 30 cases recalled "out of thin air" from an internist's office practice. It is believed that the symptoms concerned are intangible enough that they would not be well identified in a mass survey—particularly if this were of a population in a backward "test country" or a population group which was only casually or superficially surveyed. It is also true that the symptoms are common enough in any case so that perfect proof of relation of the symptoms to contraceptive medication is not easy.

The author has also seen several cases of thromboembolic disease and several cases of erythema nodosum in patients on contraceptive pills, but feels that these are infrequent problems as compared to those which are the concern of this article.

Report of cases in which contraceptive medication seemed to be provocative of major symptoms

CASE 1. Patient was first seen February 13, 1965 complaining of headaches occurring in cyclic fashion, severe in nature, and often accompanied by nausea, vomiting, and photophobia. Patient had been on norethynodrel with mestranol, 5 mg, for three years. Treatment as for migraine was carried out. On September 23, 1965 the patient was seen complaining of symptoms of depression and tension of several years duration. The patient also stated her migraine had been severe for several years. Again it was noted she had been on norethynodrel with mestranol, 5 mg, approximately three and one-half years. At this time the patient was advised to take a vacation from her contraceptive medication and use some old-fashioned technique for pregnancy prevention. The patient was next seen on February 24, 1966 and she stated that the depression, tension and migraine headache seemed to abate promptly when the contraceptive pill was stopped. The patient stated that until she had quit the contraceptive pill she felt that "I had made a mistake in my marriage or married the wrong man or marriage was not for me" and the patient stated that now she was "happy, marriage was wonderful and I had no idea it could be this wonderful." The patient was last seen on July 8, 1966 and was continuing to feel quite well and had no complaints.

CASE 2. The patient was seen on July 22, 1965 complaining of fatigue and some intermittent depression which had been present for one year. She had been on norethindrone with mestranol, 2 mg, for one and one half years. No physical problems were identified on complete examination and she was advised to stop the contraceptive and was given desipramine 25 mg four times daily for a few days. The patient was next seen on August 21, 1965 feeling very well in all respects. She stated she was "better than in a long time. Everybody notices it." She was advised not to resume the contraceptive medication.

CASE 3. The patient was seen on September 29, 1966 complaining of being "run down, grouchy and irritable" since October 1965. She also complained of chronic fatigue and loss of normal libido. She had been on chlormadinone with mestranol since October 1965. She came to me at the insistence of her husband. She was advised to stop the contraceptive pill. No other medication was prescribed. When seen one month later she had no residual complaint.

Report of cases in which the patient switched from one of the older formula contraceptive medications to one of the so-called second generation type sequential contraceptive pills

CASE 1. The patient was seen on August 30, 1966 complaining of headaches which had been quite frequent for six months. They often occurred as often as three times per week. They were usually right sided and often associated with some scotomata and nausea. She also complained of some mild depressed feelings during the previous 12 months. Interrogation about medication revealed that the patient had been on chlormadinone with mestranol for the past 12 months. Prior to that she had been on norethindrone with mestranol for nine months and prior to that had been on norethynodrel with mestranol. It appeared that the sequential type had been associated with the period of greatest symptomatology.

CASE 2. This patient according to her statement was started on norethynodrel with mestranol, 5 mg in January 1965. She was married in February 1965. On May 19, 1965 she consulted me complaining of fatigue, irritability, depression, and frequent generalized headaches. She was advised to take desipramine 25 mg three times daily after meals. On May 29, 1965 she stated she felt somewhat improved. She was advised to stop norethynodrel with mestranol and start chlormadinone with mestranol. When seen on September 30, 1965 she stated she was somewhat improved in reference to the depressed feelings and headaches. She discontinued all contraceptive medication in January 1966 in order to become pregnant.

Report of cases in which contraceptive medication seemed to be aggravating an already existing depressive problem

CASE 1. This patient had been hospitalized for neurotic symptoms and depressive reactions as far back as 1958. This condition was severe enough to require care under a psychiatrist in a psychiatric unit. She continued to be troubled with various emotional symptoms especially those of depression periodically. The symptoms seemed to be considerably accelerated between 1962 and 1966 and she was almost constantly under psychiatric care with multiple drugs, group therapy, discussion therapy, etc. History was given to me on July 2, 1966 by the patient that she had been on contraceptive medication since 1962. She took norethynodrel with mestranol from 1962 until 1965 but discontinued it because of "constant vomiting." She was next put on norethindrone with mestranol by another physician and took it for approximately one year but discontinued it in February 1966 because of an increase in headaches which she was convinced had been caused by the drug. Emotionally the patient has been better since February 1966 when all contraceptive medication was discontinued.

CASE 2. This patient had been under psychiatric care for some six years for presumed schizophrenic reaction marked chiefly by depressive symptoms. At her request she was started on norethynodrel with mestranol, 5 mg, as a contraceptive measure on April 1, 1964. The treatment with this drug was marked by considerable breakthrough bleeding, nausea, increased fatigue and breast soreness. She continued with this medication however and on March 5, 1965 was complaining of severe headaches. She stated that headaches had been recurrent since age 18. However, they had been much more frequent in the past eight to nine months. They were usually of generalized pounding type with blurred vision, nausea, dizziness, etc. During this period of a year the patient was in and out of a psychiatric unit on several occasions. Her depressive symptoms were much more marked. In the latter months of 1965 the patient discontinued the medication on her own advice because she was convinced it had aggravated her depression. She has been somewhat improved since that time.

Report of cases in which contraceptive medication seemed to have been provocative of major symptoms but the patient would not discontinue medication

CASE 1. This patient was seen on June 2, 1966 complaining of weight gain of 15 pounds in eight months, also of sluggishness, tiredness, tension and depression especially in the preceding eight to 12 months. The patient had been on norethynodrel with mestranol, 25 mg, since November 1965. The patient also stated that since the taking of this medication she had been sexually disinterested. Complete physical examination was entirely negative except for chloasma. The patient was advised to stop the contraceptive medication because of multiple probable side effect problems. The patient stated that this was impossible. She said that both she and her husband would not be satisfied with anything less than 100% assurance against pregnancy. She stated that she and her husband (both of whom were 23 and had been married one and one half years and had one child) did not wish any more children "ever." The patient said that unless I could see that her husband was operated to render him sterile she could not under any circumstances discontinue the pill no matter what it caused.

CASE 2. This patient began norethindrone with mestranol in June 1964. When seen on September 29, 1966 she stated fatigue had been constant since the fall of 1964. Also, she had gained considerable weight and felt herself to be 25 pounds above desirable weight. She also had chloasma. She wanted to lose weight, then discontinue the contraceptive, and have another baby—in that order. She felt that she couldn't lose so long as she took the contraceptive pill and couldn't afford to get pregnant as overweight as she was. When previously treated elsewhere, she had been told to continue the birth control measure and take an anorectic pill, diethylpropion hydrochloride. So, I saw her as a female who was fat, fatigued, pigmented, infertile and confused as to what to do next. I told her to stop all pills—but she remained fearful and dubious when last instructed.

Discussion

It should be pointed out that the author has not prescribed these pills for contraceptive pur-

poses for some two years, hence he is not often seeing these problems in patients to whom he has given the prescription but rather in patients who have been given the medication by other doctors.

All of the side effect symptoms mentioned in this article are mentioned in contraceptive drug information pamphlets, yet it is not considered unusual that more physicians have not warned urgently of these side actions. It should be pointed out that these medications have been in general use scarcely seven years. Yet it took some ten years to realize some of the major drawbacks of long term use of cortisone in rheumatoid arthritis. It probably took 40 years to realize the problems of aspirin usage in people with recurrent duodenal ulcer. Many physicians today are still not well aware of the depressive potentialities of rauwolfia drugs even after 15 years of use of this type drug.

Further it should be pointed out that any moribidity from these pills occurring in a healthy woman in whom they have been prescribed for purely contraceptive purposes is a violation of the medical maxim "Primum non nocere." Such pure contraceptive application of the pill may be seen in a teenage girl about to be married, who instead of simply getting happily married, gets married and then gets sick. The pill may be applied in a 30-year-old happily married women who wants to become infertile and instead becomes infertile and unhappy. The pill may be given to a 45-year-old woman who wants to "stay young forever" and has been granted this option by a physician who believes that the contraceptive pill formula given in a cyclic fashion will help her stay youthful, happy, confident, regulated and young forever and ever. Hence there is offered the risk of a drug's morbidity to a woman who has no disease. This is considerably different than offering the risk of penicillin allergy to a woman who has pneumonia, or the risk of digitalis toxicity to a woman who is in cardiac insufficiency, or the risk of pyloroplasty and vagotomy to a woman who has recurrent bleeding from duodenal ulcer. Of course in cases where the contraceptive pill formula is used for treatment of a pelvic disease problem then the morbidity of the drug can be rightly weighed against the morbidity of the disease.

Actually, I don't believe the contraceptive pills are responsible for all of the fat, fatigued, fussy, fluid-filled, infertile, phallus-fearing females in the country. Maybe they are only causing one fourth of these problems.

A peculiarity pointed out is that these pills, when properly used, are essentially 100% perfect insofar as their efficacy in preventing conception. On the other hand their safety is certainly not 100%. The drugs then must be weighed against the use of some other contraceptive modality which may not be 100% efficacious but which is 100% safe in terms of morbidity. It is rather ironic that some women are not willing to trade 100% efficacy for 100% safety. It is unusual in practice to have patients so fiercely in favor of a pill that they will get them from some other physician and take them in spite of strong contrary advice and even in the face of the woman's own adverse experience. On the other hand the author has been fascinated to see that several women have come into his office recently asking for advice about the stopping of the pill and the starting of some one of the other old-fashioned measures. This picture contrasts sharply with some three to five years ago when his appointment book was often spotted with the names of women coming in to get off the old-fashioned contraceptive program and go on the pill. Tempus fugit.

A minor observation of the author has been that patients having migraine while taking contraceptive medication seem refractory to the usual preventative and treatment preparations for migraine.

Another problem has been the medical subdivision of the American patient. Certainly the American female patient is staked out in sections in most medical communities; hence the hand that writes the prescription for the contraceptive medication may not be the hand that does the Papanicolaou smear and pelvic exam nor yet the hand that writes the prescription for antidepressant pills and antimigraine drugs. I have observed repeatedly that women will get their contraceptive pill prescription from one physician and when the side effects occur consult another doctor in reference to the problem. This second doctor may not know what, if any, other medicines the patient is taking unless he asks. It is certainly true that the left hand does not know what the right hand does, nor yet what the "pill" is doing.

It is not considered reasonable that there be any mortality or morbidity in a pill used purely for contraception purposes. Medical research has got to offer something better than this. It is believed that physicians will look back on this contraceptive pill era of the past five years with some embarrassment.

Reports of cases in which contraceptive medication had possibly been the cause of major side effects and for which the patient came to a doctor to have the medication stopped but he would not

CASE 1. Patient was first seen on September 28, 1966 in the psychiatric wing of a general hospital. The patient had been admitted for tension and depression symptoms which had begun some 12 months before. The patient stated that she had been started on norethynodrel with mestranol some 15 months before—that is about three months prior to the start of the depressive symptoms. A few months after the onset of the depression she consulted the physician who had started the contraceptive medication and asked him if it were possible the pills could be causing her to feel so badly. He advised her it was not possible and she continued the medication for another few months. She then discontinued it on her own.

CASE 2. The patient was seen on July 15, 1966 complaining of bloating, weight gain of ten pounds in one year, also frequent headaches. These headaches were often occurring twice weekly, were frontal in location and were associated with nausea and vomiting. The patient also complained of lack of energy and a chronic fatigue in the past six months. She had also observed a lack of libido in the past six months. The patient had consulted another physician in February 1966 and asked whether the headaches and lack of energy could be related to the taking of norethindrone with mestranol, 2 mg, which she had been on since approximately July 1965. He told her this was not possible, but she discontinued the medication and when seen two weeks later had already experienced some relief from her major symptoms.

Abstract

In the past two years in his office practice as an internist the author has seen cases of major side effects in patients receiving contraceptive pills. These side effects included symptoms of depression, fatigue, tension, lack of libido and acceleration of migraine type headaches. The author feels that these problems are more common than believed and that physicians should recheck patients on contraceptive type pills carefully at six-month intervals using a check list of the contraindications, warnings, precautions, side action and dangers as listed in any of the literature accompanying the medications themselves or their promotional advertising.

FAMILY REHABILITATION AS AN OBJECTIVE OF COMPREHENSIVE CARE FOR CHILDREN

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Changes in family composition, income and housing were common in a sample of 203 families served by the Maternal and Child Health Clinic of The Johns Hopkins School of Hygiene and Public Health.

One family characterizes the 70% of the families whose conditions improved during enrollment and a second family characterizes the 11% of the families who suffered adverse changes leading to welfare dependency. In the latter, the family's ability to meet the needs of their children deteriorated until it dramatically terminated in emergency placement of all children in foster homes. This progressive deterioration was accompanied by more frequent diseases among the children and by a poorer pattern of utilization of medical services. In contrast, the successful family had decreasing frequencies of disease in their younger members, and increasingly appropriate utilization of medical services.

To state how the social adjustment of these two families were effected by comprehensive health services, it appears necessary to go beyond basic clinical observations. Ecologic, sociologic and psychologic subjects for study are suggested by public health nursing, social work, and pediatric reports. Application of these sciences may document the impact of the practicing physician or of comprehensive health services on family rehabilitation.

Family composition, interpersonal relationships within the family, and the home environment undergo changes during the time that a child or family is known to a health agency. Practicing physicians and other professionals who seek to maintain a relationship with a family beyond a single disease episode assume that advice about health, social services, referral to community agencies and counseling will have favorable effects upon these changes. The ultimate effect of a continuation of these efforts in a multi-problem or "hard core" family may be called family rehabilitation. Such an objective seems so remote from giving immunizations, treating sore throats, teaching a mother to prepare a formula, that it is rarely included in the stated objectives of a pediatric service. Even the objectives of family case work in hospital, child guidance, or educational settings, tend to state their objectives in terms of the index child or the crisis that brings the family to the social service. The total effect on the family of multiple small services over an extended period of time rarely provides the basis for financing services. The relationship between the specific service given to an individual in the family and the eventual successful development of that family may be both a tacit assumption and a motive of the professional persons but has not become part of the evaluation of our services.

Purpose

The purpose of this paper is to outline the ten-year experience of a comprehensive clinic as a context for two family case histories which will dramatize the magnitude of changes which families undergo and which will suggest instances in which comprehensive services participated in the family's success. Elementary observations of case histories suggest methods of measuring changes in a family that either contribute to the child's pathology or that reflect the value of professional assistance in family rehabilitation.

The Comprehensive Care Program

The Maternal and Child Health Clinic of The Johns Hopkins School of Hygiene and Public Health opened in 1952 as a home and office-care clinic with pediatric, public health nursing, social work and psychological testing services. Families were invited to attend the clinic if they were eligible for ward medical care, lived in a low income area of the city, were members of the Negro race, the parents were married, and they were not on welfare. These admission criteria were selected to maximize the opportunity for long range observations of families. If parents separated, or if their economic condition changed, the children continued to receive comprehensive services, unless they moved beyond the specified boundaries within the city. Services were given in the home and in the clinic. Treatment of acute illness, follow-up of a chronic disease, as well as well-child services, were given free of charge.

Population

Three hundred and thirty-three families were admitted during the first ten years of clinic operation. After 12 years 223 families were either attending the clinic or were still located in Baltimore. Two hundred and three of these were available for an interview in their home by a social worker who recorded detailed information about their current socio-economic status. Ninety-four of these families had attended the clinic for more than ten years. The families who were not interviewed included those that were not at home on three separate visits by the interviewer or had attended the clinic less than two years.

Results

Socio-Economic Changes in 203 Families:

At the time of the survey 33 of the mothers were widowed, separated, or divorced, without remarriage. Eight mothers had remarried. Eight of the original mothers were no longer with their children because of death, divorce, or desertion. In 33 families one or more children were living in another home or in an institution. Although 22 families were supported by welfare at the time of this survey, because of illness or absence of the father, 92 families were earning between $5000 and $10,000 per year. Eighty-eight families were buying their homes. Thirty-one fathers and 49 mothers obtained further education during their period of clinic enrollment. Over 70% of the families reported that their financial conditions had improved since clinic enrollment.

Family Social-Medical Histories:

The following medical histories of children born at five year intervals in two families will illustrate some of the relationships between the family's changing social conditions and the child's health. Both families received comprehensive health services between 1952 and 1966.

The J Family

Mr. and Mrs. J were born in rural areas of southeastern states. They came to Baltimore as young adults. Each had had one child by a previous marriage. Mrs. J was 21 and Mr. J was 35 at the time of their marriage. One year prior to entering the clinic, Mrs. J had active tuberculosis that was adequately treated in a sanitarium on an out-patient basis. They reported no other contagious, familial or allergic diseases. Mr. J was a laborer in a steel plant. Mrs. J occasionally took work as a domestic. They lived in a 12-foot wide row house entered by poorly repaired wooden steps, heated by kerosene-burning space-heaters, located on a narrow street with a small grocery store on one corner and a bar at the other corner of the block. Mr. J continued with his job at the steel mill. In their fifth clinic year the family moved to a new house 18 feet wide, with porch, front lawn and shrubbery.

Physicians made visits to the home for one communicable disease, two acute illnesses, for one family conference, and in two instances to see newborn infants. Mrs. J kept all appointments for well child visits and follow-up of illness. She asked for family planning advice and used either diaphragm or a contraceptive cream. Her husband desired a large family. She had normal pregnancies in the fourth, sixth, and ninth clinic years. She had a non-medical septic abortion which was treated in the medical center in the tenth year of enrollment in the clinic. She then obtained tubal ligation. Her seven pregnancies had resulted in six living children born within fifteen years.

Deborah J—Born at Time of Family's Admission to Clinic

Deborah was the result of her mother's third pregnancy; it was complicated by pyelonephritis. She weighed 2800 grams at birth. For the first two years of life, her weight followed the 50th percentile growth curve. By the fifth year of life, it reached the 75th percentile where it remained and was typical of the slightly above measurements of her growth and development. Her illnesses in the first five years of life included three occasions when insect bites were severe enough to warrant medical attention. At age two, she had a burn on her leg which progressed to severe cellulitis requiring hospitalization. In her third year, she had episodes of impetigo, rubeola, varicella, mumps, and rubella. Mild atopic eczema first appeared at age five. In Deborah's second five years, she had one episode of acute pharyngitis and an occasional mild upper respiratory infection. She developed myopia which was corrected by glasses. Her teacher described her as the smartest girl in the class.

Gary J—Born in the Sixth Year of Clinic Attendance

Gary's prenatal experience was uncomplicated. His weight curve fluctuated between the 50th and 75th percentile. He had atopic eczema in his first two months of life but has since been free. At age four, he developed ringworm of the scalp. At age five, he injured his hand with a screw but the resulting infection was promptly treated. He had a paronychia of two fingers which he sucked habitually at age five. The mother was not alarmed at the finger sucking which the child gave up after two more years. One episode of otitis media was the only illness beyond minor respiratory infections.

The H Family

Mr. H was born in rural North Carolina. Mrs. H has always lived in Baltimore. At the time of their marriage, Mrs. H was 14 years old and Mr. H was an 18 year-old Marine Corps private. They had been married four years when they were registered in the clinic at the time of the birth of their fourth child, Richard. Mrs. H had rheumatic fever at age eight but has had no recurrence. Mr. H had a gonococcal infection and a hospitalization in the Veterans Hospital for fainting spells in the recent past. Following discharge from the service, he worked in a steel mill, a shipyard, a cooperage, and in construction work. Mrs. H occasionally took work as a domestic. Their home was a four-room row house heated by a gas stove in the same neighborhood as Family J. The furniture was in poor condition. The house was dirty and often filled with flies.

Mr. H had already had difficulty in keeping a job. After recurring hospitalizations for lymphadenitis and pleural effusion caused by an atypical mycobacterium, he had increasingly longer periods of unemployment. On several occasions, he left the home for more than one month. He increased his use of alcohol and became abusive to his wife. The family moved

to public housing in a high-rise apartment and later moved to a two-story apartment in public housing.

Mrs. H was pregnant each year with only two exceptions. After attending the clinic one year, Mrs. H made repeated requests for information about family planning and complained frequently of too many children at too young an age. She was unable to keep several referrals. When she obtained a diaphragm, her husband criticized its use. In the sixth clinic year, she requested a tubal ligation but her husband could not be found to sign the permission for operation. After that, tubal ligation was planned several times but not completed until the eleventh clinic year. A septic abortion in the ninth clinic year was one result of multiple delays. The causes of interruption of these plans included a primary tuberculosis infection, inability to obtain a housekeeper for the children, and insistence by one hospital on hysterectomy (which was refused) instead of the ligation.

Mr. H left the family in the fifth clinic year and subsequent pregnancies were the responsibility of a Mr. R who married Mrs. H in the twelfth year of enrollment. After the desertion of Mr. H, the family was dependent upon welfare support except for money given by Mr. R for his own children. In spite of being on welfare, the oldest boy received a new bicycle at age 10. Although free medical services were available, the family did not obtain an operation for a large umbilical hernia, removal of a nevus on the sole of the foot, and needed glasses for members of the family. The family made many night telephone calls to physicians. Two children received as many as nine house calls. With Richard, whose history will be presented, Mrs. H broke 10 appointments out of 24 given for well child care and follow-up visits in five years. Out of 19 appointments given to the eleventh child, nine were broken. School attendance of the children became increasingly irregular; the older children sometimes stayed home to care for younger ones or to take small jobs. In the twelfth year of enrollment, Mrs. H was jailed two months for shoplifting and her 12 children were placed in foster care.

Richard H—Born at Time of Family's Admission to Clinic

Richard was the result of a pregnancy complicated by a syphilitic infection which was treated in the third month of pregnancy. His growth in the first year of life followed the curve of the 50th percentile but fell to the 20th percentile in the second year. In his second year of life, his mother complained that he was a restless sleeper. In his first five years of life, he had two episodes of otitis media, a burn of the arm and hand from a space heater, two falls down a full flight of stairs, a laceration of his tongue from another fall, paronychia of the big toe, rubeola, mumps, and one illness with angioneuotic edema.

Valerie H—Born in the Fifth Year of Clinic Attendance

Valerie was the eighth child in the family. Her illness experience in the first five-year period was more severe than her brother in his pre-school period. In spite of this, her weight curve stayed in the 60th percentile. By age one, she had had hemophilus influenza conjunctivitis, and three episodes of acute bronchitis. In her second year, she had varicella, bronchopneumonia, acute bronchitis, and at least four episodes of pharyngitis. In the next three years, she had two episodes of pneumonia, two attacks of bronchitis, and two of acute pharyngitis. She was also treated for iron deficiency anemia.

Earl H—Born in Tenth Year of Clinic Attendance

Earl was the twelfth child in the family. He gained rapidly for the first year but gained only one pound in the next nine months. In the next two years, he had streptococcal pharyngitis, otitis media, two episodes of bronchopneumonia, a second degree burn on his back, and ringworm of the scalp. His frequent illnesses and frequent broken appointments allowed him to receive only two immunizations.

Discussion

These case histories illustrate some of the factors influencing changes which occur in families. The financial changes are obvious as well as the changes in family composition. Family J has had increasing financial success and increasing experience in parental cooperation while Family H has had decreasing success in both areas until they reached complete dependency, disorganization of the original marriage and sepa-

ration of the children from their mother. Both fathers objected to family planning practices: Mr. J stated that he enjoyed his children and hoped for a large number of children around him; Mr. H criticized his wife's method of controlling conception. Counseling with Mr. J was successful. Mr. H could hardly be reached. The second father for Family H has made definite efforts to take increasing responsibility for his children; employment counseling may play a crucial part in helping this family regain financial independence and cooperative parental roles.

The mothers' personalities were powerful determinants of the health experience of the children. Mrs. J's use of medical services illustrates organized purposeful effort. Mrs. H appealed to the sympathy of professional persons but was often disorganized and aimless in obtaining care. When the children were in obvious discomfort, we comforted them and brought them to the physician. Confronted with failures to get immunizations or to get the children to school, she described the difficulties that beset her and the things the children wouldn't do; the causes seemed outside of her responsibility.

Both families experienced tuberculosis. The chronic illness with a mycobacterial infection disrupted Mr. H's employment and probably affected his relationship with his family. Whether or not Mrs. J's tuberculosis disrupted her first marriage is not clear. Yearly skin tests of the J children demonstrated the vigorous health service necessary to assure this family of protection from TB. The activation of Mrs. H's TB following a pregnancy and the primary lesion in the son could have had disastrous effects if not identified at that time. Mrs. H's poor use of prenatal care probably prevented its earlier recognition.

The frequency of night house calls to the H family and the absence of such calls for the J family is consistent with the dependent personality of Mother H or consistent with her vacillation between responsible adult action and self-pity.

Measurement of Changes in a Family:

Medical literature is making increasing use of measurements of social class. These technical instruments would be valid in describing the upward mobility of the J family and the downward social mobility of the H family. They would employ the data included on family income, the nature of employment of the father and characteristics of the housing.

The specific observations added by physicians, public health nurses and social workers on home visits are relevant to sources of accidents, burns or contaminating filth. They also include information on the patterns for sleeping, eating, clothing, gift giving, work-assigning and playing. These observations may be included in an ecological description of the family but they were obtained in these families without benefit of the systemization for methods of measurement from the science of ecology. The present use of the information is for clinical deductions concerning accident prevention, health advice, interpersonal relationships and the personalities of the parents and children.

The observations of the home are important to the physician in adapting his recommendation to the circumstances and abilities of the persons involved. The validity of his deductions may be low even when he has as many observations as this clinic had of the H family. The deduction that Mrs. H had a dependent personality is based upon instances in which she elicited assistance, support, favors or gifts from other persons, and other instances in which she did not take responsibility for independent action. Although this may be useful it may be erroneous unless the observers were given systematic instructions by psychologists and/or sociologists to make such classifications and to relate the classifications to behavior affecting health.

Among the differences between these two families is their behavior in planning the size of their families and their adaptation to a large number of children in the home. This behavior and adaptation went through a series of stages employing different birth control techniques and different levels of concern for the size of the family. The description of these stages are relevant to the social science of family development and to the services for family planning and population control.

These comments invite further participation by ecologists, sociologists and psychologists in the study of child health. Improvement of methods and practices for increasing precision of observation may serve to document the impact of the practicing physician or a comprehensive health service on the social changes of the families that they serve.

YOUR MEDICAL FACULTY AT WORK

John Sargeant
Executive Secretary

The Executive Committee at its March 7, 1968 meeting took the following actions:

1. Authorized payment of expenses of the Emotional Health Committee chairman to attend a national meeting in Chicago; and a representative of the subcommittee on Medicine and Religion to attend a regional meeting in New York City.
2. Heard a report from the Parliamentarian requiring that physicians who were members at the time of the 1965 assessment are now required to pay that assessment in order to be currently reinstated to membership.
3. Authorized the Public Relations Chairman to serve as an advisor from the Faculty to the Student American Medical Association, University of Maryland Chapter.
4. Made recommendations for possible appointments as:
   a) Medical Advisory Committee, Division of Vocational Rehabilitation, for the Eastern and Western Districts of the State
   b) Board of Physical Therapy Examiners
   c) Advisory Council on Hospital Construction
5. Heard that the Blue Shield Board has voted not to make payments directly to lay laboratories.

Physicians are reminded of the portion of the Medicolegal Code of Cooperation pertaining to Reports to Patient or his Attorney which reads as follows:

> "The patient, or his attorney, upon written request, when accompanied by a signed authorization from the patient, shall be entitled to a prompt report from the attending physician, containing the history, physical condition, diagnosis, and prognosis, but need not include an evaluation of disability in Workmen's Compensation Cases. The physician's fee for such report should be commensurate with the time and effort devoted to its preparation."

This reminder is given because there have been many reports of insurance carriers advising physicians not to submit their medical reports to plantiffs' attorneys. If you have any questions, please contact the Faculty office for clarification.



Dr. Bard

Later this month, during the Annual Session of the American College of Physicians, Philip Bard, PhD, of Baltimore will receive the ACP Award for distinguished contributions in science as related to medicine.

PHILIP BARD PHD, TO RECEIVE ACP AWARD

Dr. Bard, an expert in neuro-physiology, is Professor Emeritus of Physiology at The Johns Hopkins University School of Medicine.

The distinguished physiologist was born in Hueneme, Cal. in 1898. He was a student at the Thacher School in Ojai, Cal., but migrated to the East for his college education. Dr. Bard received his AB from Princeton University in 1923, and his PhD from Harvard in 1927. He served as a Teaching Fellow and Instructor in Physiology at the Harvard Medical School from 1925 to 1928. From 1928 to 1931 he was Assistant Professor of Biology at Princeton then returned to Harvard for two years as Assistant Professor of Physiology and Tutor in Normal Medical Science. He was named Professor of Physiology and Director of the Department of Physiology of The Johns Hopkins University School of Medicine in 1933 and served in this capacity until 1964. In 1953 to 1957, he also served as Dean of the Medical Faculty; and in 1964 he became Professor Emeritus.

Dr. Bard is a member of the National Academy of Sciences, American Philosophical Society, American Academy of Arts and Sciences, Association of American Physicians, American Physiological Society (President, 1942-1946), American Neurological Association, Society for Experimental Biology and Medicine (President, 1956-1961), Association for Research in Nervous and Mental Disease (President, 1950), AAAS, Phi Beta Kappa, and Sigma Xi.

He is an honorary member of the Facultad de Biologia y Ciencias Medicas, University of Chile; Sociedad Argentina de Biologia; and Sociedad Medica de Santiago, Chile. From 1935 to 1946, Dr. Bard was a member of the National Board of Medical Examiners. During World War II, he served on three committees on the Military Medicine of the National Research Council.

Dr. Bard has been a Harvey Lecturer; Hughlings Jackson Lecturer, Montreal Neurological Institute; George Cyril Graves Lecturer, Indiana

University; Mitchell Lecturer, College of Physicians, Philadelphia; Glenn Millikan Lecturer, Vanderbilt University; and has received the Jacoby Award of the American Neurological Association; Karl Spencer Lashley Award in Neurobiology, American Philosophical Society.

Among his honorary degrees are listed DSc from Princton in 1947; ScD from Washington and Lee University in 1949; Doctor, Honoris Causa from the Universidad Catolica de Chile and the Universidad Mayor de San Marcos de Lima in 1951.

Dr. Bard has been a member of the Editorial Board of American Journal of Physiology; chairman, Editorial Board of Physiological Reviews; chairman, Board of Publication Trustees and Publications Committee of the American Physiological Society; Editor of and contributor to Macleod's Physiology in Modern Medicine, 8th, 9th editions; Medical Physiology, 10th and 11th editions. He has published about 60 papers on neural bases of emotional sexual behavior, postural reactions, localization of function in cerebral cortex, motion sickness, neural control of pituitary gland, temperature regulation and central nervous mechanisms involved in production of fever.

Dr. Bard was married in 1922 to the late Harriet Hunt, and is the father of two children, Virginia Hunt (Mrs. Moulton K. Johnson) and Elizabeth Stanton (Mrs. Jack P. Stephens). In 1965, he married the former Janet Mackenzie Rioch, MD.

Other Maryland doctors who have been named to receive awards this year include **Donald S. Fredrickson, MD,** Director of the National Heart Institute of the National Institutes of Health in Bethesda.

Dr. Fredrickson was this year's recipient of the American College of Cardiology's Convocation Gold Medal. Presented at the College of Cardiology's 17th Annual Scientific Session recently held in San Francisco, the medal was awarded with the citation: "In recognition of your dedication to the advancement of knowledge in the field of heart disease and your devotion to public service."

Bernard Weiss, MD, of The Johns Hopkins University, and **Joseph Wells, MD,** of the University of Maryland, have been awarded grants by Lederle Laboratories for their dedication to medical teaching.

The awardees were selected by a committee composed of seven leading medical educators under the direction of Maxwell Finland, MD, a George Richards Minot Professor of Medicine at Harvard Medical School.

The American College of Gastroenterology has announced the winners of the 1967 Rorer Awards.

Under the category of best unpublished papers, **Capt. William M. Lukash** of Bethesda, Head of the Gastroenterological Clinic of the National Naval Medical Center, won third prize for his work, "Rehfuss Fractional Gastric Analysis: A Study of Secretary and Motor Function of the Stomach."

For the best papers published for the year ending June 1967, third prize was awarded to **Vernon M. Smith, MD,** of Baltimore, for his paper, "Peritoneoscopic Cinematography."

Several appointments have been announced, including that of **Theodore Cooper, MD,** as Director of the National Heart Institute succeeding Donald S. Fredrickson, MD, who will return to the field of clinical investigation as Chief of the NHI Laboratory of Molecular Diseases.

Prior to his appointment as Director, Dr. Cooper served as the Associate Director and Chief of the Institute's Artificial Heart-Myocardial Infarction Program.

* * *

Sanford M. Bienen, PhD, has been appointed Special Assistant to the Director of the Mental Health Study Center in Adelphi.

A psychologist, and former assistant to the Director of Planning, Maryland Department of Mental Hygiene, Dr. Bienen is also a former member of the faculty of the University of Maryland.

The American Medical Association has reappointed the **Rev. William Loveless** of Takoma Park as a member of the Committee on Medicine and Religion.

The AMA Committee, composed of both physicians and clergymen, works to create the proper climate for communication between the physician and the clergy that will lead to the most effective care and treatment of the patient.

John J. Curry, MD, of Silver Spring, has been reappointed a member of the Council on Drugs of the American Medical Association.

Composed of medical experts appointed by the Board of Trustees, the AMA Council provides authoritative and unbiased information on drugs to the medical profession to encourage rational therapy.

The reappointment of **Harry M. Robinson, Jr., MD,** to the Subcommittee on Skin of the American Medical Associations' Committee on Rating of Mental and Physical Impairment, has been announced.

The Committee is developing a series of practical guides to assist physicians in evaluating permanent impairment. Each guide is prepared by a group of specialists concerned with the area of the body being considered.

The AMA Committee on the Medical Aspects of Automotive Safety has announced the reappointment of **Abraham J. Mirkin, MD,** of Cumberland as a member.

The purpose of this Committee is to develop medical information for the practicing physician, enabling him to advise and inform his patients concerning hazards which may result when the driver has abnormal physical conditions, certain diseases or emotional disturbances, or when he uses drugs and alcohol. The Committee supplies information to the public regarding medical conditions which may adversely affect driving proficiency, and encourages automotive designers and engineers to study and improve safety features in vehicle design.

Russell S. Fisher, MD, of Baltimore has been reappointed chairman of the Committee on Medicolegal Problems of the American Medical Association.

The principal areas of concern of this Committee include medical professional liability, liability insurance for physicians, medicolegal education, chemical tests for intoxication, forensic medicine, and medical testimony.

The University of Maryland Board of Regents has approved the appointment of **William J. Kinnard, Jr., PhD,** as dean of the School of Pharmacy, effective July 1.

Dr. Kinnard comes to Maryland from the University of Pittsburgh School of Pharmacy where he has been a member of the faculty since 1957, chairman of the curriculum committee since 1965, and full professor since 1966.

The February 26th issue of MODERN MEDICINE featured **A. McGehee Harvey, MD,** chairman of the department of medicine at The Johns Hopkins University, and physician-in-chief at The Johns Hopkins Hospital.

Dr. Harvey, selected by the journal editors as their "Contemporary" for the issue, has devoted a large part of his medical career to the question "How does man move?" His interests in this area, dating back to 1932, ultimately led to a quantitative technique for studying neuromuscular function in man, and "opened the door to meaningful studies of the pathogenesis of certain diseases," the journal states.

The Commonwealth Fund, a philanthropic foundation based in New York, has granted $270,000 to **The Johns Hopkins University School of Hygiene and Public Health** for the implementation of plans within its medical center to help establish studies of medical services and care as a major new phase of medical learning, comparable in significance to the best work being done in the biomedical and clinical sciences.

Responsibility for leadership in the University's decision to build up the health-studies field as a strong component of its objectives in medicine and health will be centered in the Department of Medical Care and Hospitals—recently established by the School of Hygiene and Public Health and headed by Dr. Kerr L. White, one of the country's foremost scholars and educators in the health disciplines.

Since joining The Hopkins in 1965, Dr. White has brought together a nucleus of able faculty representing the diverse range of disciplines involved in medical-care research; and this group provides the school with a solid starting base for expanding its work in the health field into a University-wide interest.

The Department of Medical Care and Hospitals will participate with faculty in the School of Medicine and in other parts of the university in experimental projects to explore and demonstrate improved medical-services systems, such as a comprehensive health-care program in the new city of Columbia. The main emphasis of the Department will be to strengthen the academic foundations on which such projects are based.

The Department has developed a four-part program directed toward this purpose. The Commonwealth Fund's grant provides support over an initial period of three years for added faculty, visiting scholars, and other costs of implementing the program.



An original oil painting of The Johns Hopkins University School of Medicine was presented to Thomas B. Turner, MD, dean of the school, by a representative of the E. R. Squibb & Sons, Inc. pharmaceutical firm on March 14. The painting, executed by Stuart Garrett, is part of a long-range plan by the firm to create a collection of original oils of the medical colleges of America. The project, known as "Collegia Medica," will be continued until representative paintings of all 86 medical schools have been completed.

The Heart Page

CHRIS PAPADOPOULOS, MD, EDITOR

A service of the Heart Association of Maryland

Risk Factors and Coronary Disease*

Current intensive efforts to provide therapy for persons who have already developed coronary heart disease will undoubtedly save lives. However, in view of the natural history of this disease, it appears likely that its morbidity and mortality can be substantially reduced through education and management aimed at preventing or retarding the development of atherosclerosis and its thrombotic complications. This can be said despite uncertainty concerning the exact role of many of the factors believed to contribute to the rate at which lesions develop in individual vessels. While the epidemiologic data correlating risk factors with incidence justify public recommendations based on these data, these recommendations undoubtedly will be more sharply defined according to the results of continuing investigation.

Preventive measures should be initiated early in life to have the best chance of preventing or retarding coronary heart disease. For example, correction of established adverse eating or smoking habits, while evidently beneficial, is certainly of less value than if the improper practices were never begun.

Guidelines for referral

Epidemiologic studies demonstrate that certain factors are associated with an increased rate of development of coronary heart disease. These factors include overt problems and personal attributes which may require modification and environmental factors which are correctable. In considering the several risk factors which contribute to the rate of development of atherosclerosis, it should be recognized that no single factor is absolutely etiologic—multiple causal factors play interrelated roles.

Overt Problems and Personal Attributes

Familial occurrence of coronary disease at an early age
Hypertension
Electrocardiographic abnormalities
Diabetes mellitus
Lipid abnormalities involving serum cholesterol and triglycerides and their lipoprotein vehicles
Obesity
Gout (hyperuricemia)
Certain personality-behavior patterns

Environmental Factors

Cigarette smoking
Lack of physical activity
Emotionally stressful situations

Some of these factors may directly or indirectly modify the rate of development of atherosclerosis, while others, such as severe emotional stress, may precipitate an acute cardiac event. Most are subject to change in what appears to be a favorable direction, although final proof of this is lacking (with the possible exception of cigarette smoking). Additional research to provide more effective prevention is urgently needed, but enough information is at hand to advocate that individuals who are highly susceptible to coronary disease be placed on regimens designed to correct their unfavorable characteristics. This is particularly true when the early development of coronary disease is a family characteristic. It is well recognized that a strong family history of coronary disease may be due to a tendency to atherosclerosis, to hyperlipidemia, to diabetes, or to essential hypertension as the basic disorder. Many individuals, if forewarned of their susceptibility to heart disease, may be willing to follow a regimen to reduce their risks.

**From a statement Released by the Central Committee for Medical and Community Program of the American Heart Association, December 8, 1967.*

Early detection of susceptible individuals involves some form of routine surveillance for the appearance of risk factors. Most people today receive health examinations for a variety of reasons including insurance or school health examinations, periodic health checkups, and pre-employment physicals. Inclusion of certain procedures for identifying the "coronary prone" is one important approach. For such examinations to be effective, the persons with abnormalities must be referred to a physician, and the physician must be able to institute corrective measures.

It is recommended that individuals with a two-fold or more increase in risk be referred to physicians for prophylactic management. The "coronary-prone" adult with at least this level of elevated risk demonstrates one or more of the following:

1. Serum cholesterol of more than 260 mg%, a fasting triglyceride of more than 250 mg%, or a prominent electrophoretic pre-beta lipoprotein band
2. Sustained blood pressure over 160/95 mm Hg
3. Body weights 30% or more above standards listed in tables of desirable weight.*
4. Fasting blood sugar of more than 120 mg%, or a casual blood sugar of 180 mg%, decreased glucose tolerance or significant glycosuria
5. History of gout or a uric acid level over 7.5 mg%
6. Electrocardiographic abnormalities**
7. Habitual cigarette smoking

The designation of "abnormal" levels for certain of these risk factors is arbitrary. For example, risk has been demonstrated to increase from the lowest to the highest level of blood pressure and cholesterol recorded in the population.

As single abnormalities, each of these items carries at least a two-fold excess risk of coronary disease. Lesser abnormalities than the values listed may be important when two or more factors are present. Individuals with multiple abnormalities demonstrate up to a ten-fold excess risk of coronary disease. Sedentary individuals appear to be especially prone to lethal coronary attacks. The appearance of new electrocardiographic abnormalities may indicate the development of early asymptomatic coronary disease.

General Recommendations for the Physician

When patients present themselves for periodic examinations or for other reasons, identification of the factors which enhance the risk of coronary heart disease should be included in the examination. These factors should be looked for in young adults, as well as in older individuals, to permit the earliest possible identification of susceptible individuals. Once identified, long-term supervision and periodic re-examination of the coronary-prone individual are of paramount importance in establishing effective and sustained control of the factors which enhance risk. It is important that physicians develop a greater interest in the prevention of atherosclerosis rather than confine their concern principally to the treatment of patients with symptomatic coronary disease.

The preventive approach to atherosclerosis is particularly important in the care of children from families demonstrating metabolic abnormalities including the hyperlipidemias, obesity, hypertension, diabetes, gout, and early coronary disease. Preventive measures applied to these individuals early in life should be even more fruitful than those applied only after the development of overt disease.

Long-term management by the physician should include repeated evaluation of both the cardiovascular system and the several coronary risk factors. This entails periodic determination of body weight, blood pressure, blood lipids, uric acid levels, blood glucose, and ECG. A simple total vital capacity and chest X-ray for heart size are also helpful. These examinations are also required to evaluate the effect of the measures instituted to control the risk factors. Unrecognized or silent myocardial infarctions are neither rare nor innocuous and may be detected only by periodic electrocardiographic examination. Annual examinations should, therefore, be encouraged particularly in subjects exhibiting these risk factors and especially in subjects over forty years of age.

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*Metropolitan Life Insurance Co. *Statistical Bulletin*, November-December, 1959.

**These include left ventricular hypertrophy, intraventricular block, distinctly abnormal S-T segment displacement and T-wave abnormalities at rest, atrial fibrillation otherwise unexplained, myocardial infarctions, and unequivocal ischemic post-exercise S-T and T-wave abnormalities.

TUBERCULOSIS

A Service of the Maryland Tuberculosis Association

The Hazard Is Relative

Should Patients with tuberculosis be cared for in general hospitals and, if so, what precautions should be taken?

Richard L. Riley, MD

With tuberculosis sanatoria closing there is no place left for tuberculous patients who need hospitalization other than general hospitals, so the first half of this question is almost irrelevant. In regard to the second half, the May issue of the Journal will contain a statement from the Ad Hoc Committee on Treatment of Tuberculosis Patients in General Hospitals of the National Tuberculosis Association. This statement, entitled "Infectiousness of Tuberculosis,"* tells what precautions should be taken and why. I shall amplify the Committee's statement by showing how the hazard of catching tuberculosis varies in different environments and why the Committee's recommendations are appropriate for the environment of the general hospital.

Inasmuch as a single tubercle bacillus implanted on the lung tissue of a tuberculin-negative person is all that is required to infect, the hazard of infection depends upon the likelihood that such implantation will take place. This in turn depends upon the likelihood that an airborne tubercle bacillus will be inhaled, which is related to the concentration of airborne tubercle bacilli in enclosed atmospheres, and hence upon the balance between the rate at which organisms are added to the air and the rate at which they are removed. The rate of addition depends upon the character of the pulmonary lesions and the behavior of the patient, whereas the rate of removal depends upon disinfection of the air either by killing the organisms or venting them to the outdoors. To control the rate of addition one must control the patient; control of the rate of removal involves control of the aerial environment.

In the concluding paragraph of the Committee's report it is stated "that the greatest risk of infection arises from the subject with undiagnosed or unsuspected tuberculosis." Clearly one has no control over an undiagnosed and unsuspected case. By exclusion, therefore, one must approach this particular hazard by increasing the rate of removal of airborne organisms from enclosed atmospheres that people might unwittingly share with such a person. Under ordinary conditions, whether in hospital, at work, or in the community, one must place primary reliance upon air disinfection in order to avoid inhaling a tubercle bacillus. This approach, like BCG vaccination, is aimed at reducing the risk of infection from the subject with unsuspected tuberculosis.

Reprinted from THE AMERICAN REVIEW OF RESPIRATORY DISEASE, Volume 96, Number 4, October 1967.

Whether an enclosed atmosphere is safe or dangerous when shared with a person with unsuspected tuberculosis depends on the rate at which organisms are removed. A modern naval vessel, in which all the air is recirculated, provides an example of minimal removal of airborne organisms. As a consequence there have been, according to Houk and associates, six outbreaks of tuberculosis aboard ships of the U. S. Navy during the past few years.[1] One of the sharpest occurred in 1966 and was intensively studied.[2] Approximately 50% of 308 enlisted personnel at risk demonstrated new infection with *Mycobacterium tuberculosis*. Of the 66 subjects, who shared a sleeping compartment with the first person with unsuspected tuberculosis, over 80% became infected. A ship like this, in which people are crowded together and breathe the same recirculated air, can, with luck, operate for years without tuberculosis, if there is nobody with tuberculosis aboard. However, the "infectious potential" is always present, and the accidental occurrence of an unsuspected case can lead to a devastating outbreak. In such a human exposure chamber the average time required to implant a tubercle bacillus in the lung can be reckoned in days or weeks, if a tuberculosis disseminator is aboard.

Before the advent of chemotherapy, the air of Bellevue Hospital in New York was somewhat hazardous to breathe. On the tuberculosis service it was not uncommon to have two six-bed rooms occupied by recently infected doctors and nurses. The hazard appeared to be more or less the same throughout the hospital and was not unique to the tuberculosis wards. Presumably the unsuspected cases on the other wards were as dangerous as the known cases on the tuberculosis wards. Between the years 1930 and 1948, the average time for "conversion" of the tuberculin test in student nurses with previously negative reactions was about 1.5 years.[3] Hence it took perhaps ten times as long to get infected at Bellevue as it did the sailors referred to. The ventilation at Bellevue was better, and the nurses breathed Bellevue air only at work, whereas the sailors breathed their contaminated atmosphere 24 hours a day.

In the Veterans Administration hospitals the rate of "conversion" of the tuberculin test in hospital personnel was running at 2.3 for the year 1963.[4] At this rate the average time required for infection would be about 43 years, or almost 30 times what it used to be at Bellevue and hundreds of times what it was during the outbreak aboard ship. The reasons for this magnificent advance include the following: Almost all hospitalized patients are noninfectious as a result of chemotherapy; in Veterans Administration hospitals there is little likelihood of exposure to unsuspected and, therefore, untreated patients; and in V. A. hospitals ventilation per person is relatively good. The V. A. has reduced the hazard of tuberculosis to acceptable proportions by controlling both the patient and the environment.

If the Veterans Administration can take care of large numbers of tuberculous patients without significant hazard to hospital personnel, general hospitals should be able to care for an occasional patient without undue hazard. There is no reason to doubt that chemotherapy can work its magic equally well in general hospitals. It seems likely, however, that opportunities for exposure to unsuspected and untreated patients are greater in general hospitals, and that ventilation per person is less, particularly in crowded outpatient clinics and emergency wards. With this in mind the NTA Committee recommends that "ultraviolet lights be used in rooms that are likely to be frequented or occupied by patients with undiagnosed or unsuspected tuberculosis," and also in rooms occupied by "tuberculous patients in the early phase of chemotherapy." And with an eye to the day when hospital air conditioning might be modeled after naval vessels, the Committee also recommends ultraviolet lights "in air ducts when air is being recirculated."

It can be anticipated that general hospitals, which comply with the Committee's recommendations, can accept tuberculous patients and at the same time reduce the hazard to personnel to the level that currently exists in Veterans Administration hospitals. If, on the average, the chance of implanting a tubercle bacillus is lowered to once in 43 years, most people would agree that the hazard is acceptable. This does not mean that the tubercle bacillus has lost its sting, but rather that the air surrounding a person with tuberculosis can now be made relatively safe.

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Alcoholism Section

ATTITUDES AND ALCOHOLICS

ISADORE TUERK, MD
Commissioner, Maryland Department of Mental Hygiene*

In my 20 years of rich and rewarding experience in treating alcoholics and in training other professional personnel to treat them, I have become increasingly certain that the key to effective treatment of these sick people is a positive, accepting attitude toward them, based on a genuine conviction that alcoholism is indeed a disease.

The alcoholic usually comes for treatment dragging a heavy old burden of guilt, shame, and humiliation. He is, after all, a member of his society and is likely to share its general view of the alcoholic as weak and worthless. He expects the therapist to judge him as harshly as he judges himself, to blame him as bitterly as he blames himself for his behavior and its destructive effect on his family. He comes qualified as an expert on his own badness!

If, in the initial contact, the therapist reflects back to him any part of his own feelings, there can be little hope of progress toward recovery: the alcoholic's hopelessness is confirmed. If, on the other hand, the therapist, while accepting the reality of his patient's feelings, projects a very different reality in his interpretation of the disease concept of alcoholism, the alcoholic can let himself begin to hope: for disease there may be treatment and the goal of treatment is recovery.

In the course of treatment, the alcoholic will test the therapist's attitude vigorously and repeatedly. If any doubt, any confusion contaminates the therapist's professional diagnostic approach, the alcoholic will seek it out and turn it against himself. His skepticism and ambivalence about the diagnosis and treatment and the hope they represent may literally "drive him to drink," and each new drinking episode provides another test of the therapist's good faith.

Unfortunately, many professional people cannot "pass" the alcoholic's tests. They may have had no training or experience in treating alcoholics, or they may have unresolved problems about their own drinking patterns or the drinking pattern of someone they love which cripple their relationships with such patients. Consider the following examples:

The professional nurse who disapproves of admitting alcoholics to her hospital because, "there are so many really sick people who need our beds."

The social worker who greets an alcoholic on his fourth visit to a specialized in-service facility with the involuntary groan, "Oh, no, not you again!"

The physician in a tuberculosis hospital who is reluctant to diagnose his patient's alcoholism because the diagnosis is "unkind" to the patient.

All three of these well-trained and dedicated individuals would quite honestly agree with me that alcoholism is a disease. They think they believe it. But if alcoholism is a disease, are

**With the editorial assistance of Mrs. Gertrude L. Nilsson, Coordinator of Services to Alcoholics, Maryland Department of Mental Hygiene.*

(Reprinted from Labor Rehabilitation Report, *with the permission of the publisher, National Institutes on Rehabilitation and Health Services.)*

patients with other diagnoses really more sick than alcoholics? And if alcoholism is a disease, is it reprehensible that the alcoholic seeks in-patient treatment for its acute symptoms? And if alcoholism is a disease, is its diagnosis unkinder than that of tuberculosis, or diabetes, or any other disease? The answer to each of the above questions is, of course, no. The reason for asking the questions is that the well-meaning professional people I have quoted believed only superficially that alcoholism is a disease. In each case, the belief was shadowed by lingering, deep-seated suspicions that the alcoholic drinks too much voluntarily, in order to have a good time, because he wants to; or that he gets drunk because he is weak-willed or not "man enough to hold his liquor." In each case, the professional attitude is distorted by prejudice against the alcoholic patient, to which he is only too acutely sensitive.

It might be helpful to try to describe, however unscientifically, the elements that combine to create the positive accepting attitude I believe is essential to effective treatment of alcoholics.

The first has already been noted: genuine conviction that alcoholism is a disease. Such conviction gains in strength and stability with increasing knowledge about alcoholism and increasing treatment experience with alcoholics.

The second has been implied: resolution of the therapist's personal problems with drinking and drunkenness to the point that he can be as objective with an alcoholic patient as with a cardiac patient.

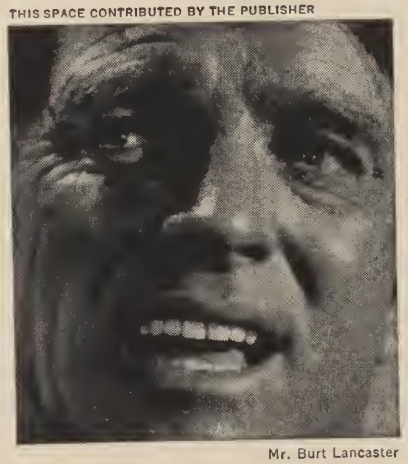
A third is humility. Although we know some things about alcoholism and some things about treating alcoholics, there are still many unanswered questions about causation, treatment, etiology, etc. The therapist must be ready not only to acknowledge what is not known or what he himself does not know, but must also be ready to learn from his patient—from what he does not say, as well as from what he does say about his alcoholic career.

A fourth is the capacity to sense beneath the often unpleasant surface of the acutely intoxicated alcoholic or the bland, ingratiating surface of the sober alcoholic, the cry for help of a desperately sick individual, complicated by self-defeating resistances to seeking and using such help.

A fifth is a high level of resistance to frustration and the willingness to keep treating in spite of what is too often condemned as "poor motivation" on the part of the patient. Treatment people in the alcoholism field must learn to be satisfied with partial goals, and to expect, and even make therapeutic use of, acute manifestations of the disease. They must question their own motivation to treat before they question the alcoholic's motivation to accept treatment.

And, finally, a sixth is willingness to share the treatment of an alcoholic with other agents and agencies: a member of Alcoholics Anonymous, a pastoral counselor, a family physician, or anyone else who might have some impact on the patient which would effectively complement the therapist's impact.

THIS SPACE CONTRIBUTED BY THE PUBLISHER



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Baltimore City Health Department

Robert E. Farber, MD, MPH, Commissioner

Health Aide Training Program

An important step toward providing nonprofessional health aides for the community has been taken by the City Health Department in inaugurating a Health Aide Training Program for unemployed or underemployed inner-city residents.

Funded for a six-month period by the Manpower Development Training Act through the Baltimore Community Action Agency's Concentrated Employment Program, the project has been made possible by a contractual arrangement of the Maryland State Department of Education, the Baltimore City Department of Education and the Baltimore City Health Department. Supportive activities will be provided by the Maryland State Employment Service.

Beginning with 25 trainees, the program will provide ten weeks of intensive class and field work that will qualify the participants for a variety of health aide positions in health agencies, hospitals, nursing homes and other similar activities. Health aides will serve in such posts as nursing or medical assistants, sanitarian aides, community aides, interviewers or receptionists.

Established through the efforts of Matthew Tayback, ScD, Deputy Commissioner of Health the new Health Aide Training Program is directed by Mr. William G. Sykes, MSW, ACSW, Chief Social Worker Consultant in the City Health Department's Child Health Services Project 606. Mrs. Nancy McAndrew, a nurse with two years' experience in teaching practical nursing, has been employed as training supervisor and instructor.

Subject areas for the ten-week course include orientation and medical terminology; health problems of Baltimore with emphasis on the inner city; health agency structure and function; fundamentals of anatomy, physiology and hygiene; basic nursing techniques and patient care; community and personal relations; and career opportunities. Class, field and clinical work will be arranged through the assistance of cooperating community agencies which, hopefully, will provide future employment for the graduates.

Headquarters for the new training program is the Southern Health District Building, 1211 Wall Street. Liaison with the Department of Education will be maintained through Mr. Joseph Zebley, Jr., Associate, Manpower Development and Training, Adult Education Program of the City Department of Education.

Queries regarding placement of Health Aides who have completed the course of training may be directed to Mr. William G. Sykes, Telephone 752-2000, Extension 2778.

Alcoholism Counselors

The City Health Department's first group of eleven alcoholism counselor trainees completed their six-month training program on March 22.

Certificates of satisfactory completion of the program which qualifies the participants for posts as alcoholism counselors were awarded to the following trainees, most of whom have already been placed in community agencies: Mary Louise Bianco, William E. Black, Richard C. Cain, Gabelle Fisher, Melvin Gill, Henry R. Hall, Judith A. Harris, Clarence W. Hurley, Jr., Paul B. Kluge, John G. Stockman, and Frances Tisdale.

The City Health Department training program for alcoholism counselors is funded through a three-year educational grant by the National Institute of Mental Health. Approximately 20 trainee stipends, several of which have been made possible by local industry and agencies, will be available for the second group which commences in April.

The alcoholism counselor program is aimed at meeting the need for semiprofessional persons who can assist and guide the growing number of victims of alcoholism to overcome their illness so they can again take their place in the community as productive citizens.

The new alcoholism counselor training project is under the direction of Abraham M. Schneidmuhl, MD, Director of the City Health Department's Alcoholism Center, 2221 St. Paul Street. Co-director in charge of education and training is Mrs. Gladys Leigh Augustus, a vice principal now on leave of absence from the City Department of Education.

Physicians are invited to call the Alcoholism Center if they require assistance with any problem dealing with the alcoholic. The telephone number is 752-2000, Extension 2756.

Woman's Auxiliary

MRS. HARRY L. BERMAN, EDITOR

THE WOMAN'S AUXILIARY TO THE STUDENT AMERICAN MEDICAL ASSOCIATION

The University of Maryland Chapter of the Woman's Auxiliary to the Student American Medical Association (WA-SAMA) is an active group of medical students' wives with enough spark to generate its activities with sweep and speed. The National Auxiliary was formed in Philadelphia, Pennsylvania in May, 1957, by representatives of the University of Maryland and 27 other medical schools. There are now 67 chapters with a total membership of 5,000.

Communication between the campuses is maintained through regional and national meetings, with local attendance made possible through the financial support given by the State, Baltimore City and Baltimore County Auxiliaries. Circulation of the National news-letter, CHATTERBOX, the Region III (Maryland, District of Columbia, West Virginia, and Pennsylvania) PRESCRIPTION PAD, and the University of Maryland NEWS-LETTER keeps the members informed of the activities of other groups.

At the beginning of each school year, a "Welcoming Tea" given at the home of a member of the Woman's Auxiliary to the Baltimore City Medical Society, honors the wives of the freshmen medical students and the summer brides of the upper classmen and acquaints them with the programs and projects of WA-SAMA. Of particular interest this year were physician speakers whose subject was "IS YOUR HUSBAND OUTGROWING YOU?", and the presentation by Joseph H. Hooper, Jr., MD on pertinent medical legislation. A mixture of fun things such as holiday parties, dances and hayrides are sprinkled throughout the year and culminated with an annual May luncheon honoring the wives of the senior students.

THE WOMAN'S AUXILIARY TO THE CARROLL COUNTY MEDICAL SOCIETY

The Woman's Auxiliary to the Carroll County Medical Society, Mrs. Charles Mawhinney, Jr., President, augmented the funds for its nursing scholarship program through a highly successful bake sale.

An outstanding community service of the Auxiliary was the creation of a "Bedside Library" for the patients in Carroll County Hospital, in honor of the county physicians. The generous gift of 150 volumes by Random House Publishing Company added to those donated by the Auxiliary create an adequate library for the patients.

Carroll County Auxilians are saddened by the death of one of their most active and outstanding members, Mrs. Lewis K. Woodward, wife of Lewis K. Woodward, MD and mother of Theodore E. Woodward, MD.



Paul F. Guerin, MD, Chairman
Library and History Committee

Elizabeth Sanford
Librarian

NEW CHAIRMAN ASSUMES DUTIES

Paul F. Guerin, MD, assumed the chairmanship of the Library and History Committee in November, 1967, following the resignation of Louis Krause, MD, from that position.

Dr. Guerin was born in Wesleyville, Pennsylvania. Following his graduation from high school in Wesleyville, he attended Wittenberg University in Springfield, Ohio, where he received an AB degree in 1942. He was awarded an MD degree from the University of Pennsylvania in 1945, and interned at the University of Chicago Clinics from 1945 to 1946. The Medical Corps of the United States Army claimed his services from 1946 to 1948, and from 1948 to 1950 he served his residency at Temple University Hospital in Philadelphia, after which he returned to the Medical Corps and was stationed in Maryland and Hawaii. In 1954 he settled in Maryland.



—Mitchell

Dr. Guerin

A former Assistant Medical Examiner for Maryland, Dr. Guerin is Director of Laboratories at Franklin Square Hospital, Baltimore. He is affiliated with Maryland General Hospital, South Baltimore General Hospital and North Charles General Hospital. He is Assistant Professor of Pathology at the University of Maryland School of Medicine. Since 1961, Dr. Guerin has been associated with Watson Kime, MD, and Edward L. Sherrer, MD, in the practice of laboratory pathology in addition to his private office schedule.

Dr. Guerin has been active in the Medical and Chirurgical Faculty and has served as past chairman, Economics Committee; chairman, Med-Chi Insurance Trust; Liaison Committee member; and a member of the Executive Committee, MMPAC. Also, he is active in a long list of professional organizations and offices, both local and national.

He is married to the former Phyllis Bacher and is the father of three sons—Richard, a junior at the Johns Hopkins University; Joel, an Oberlin College sophomore; and Michael, a senior at McDonogh.

Dr. Guerin is a member of the Mt. Washington Club, the Maryland Yacht Club, and is listed as a junior navigator with the US Power Squadron.

Serving on the Library and History Committee under the guidance of the chairman are Robert B. Goldstein, MD, Baltimore; Thomas C. Hill, MD, Salisbury; Katherine A. Chapman, MD, Kensington; Louis Krause, MD, Baltimore; and H. Baldwin Streett, DDS, Baltimore.

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SEARLE

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Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

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in sinusitis, colds, U.R.I.
Dimetapp® Extentabs®
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When the emotionally impaired patient pays an office call...

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When not at your office, she's constantly on the phone: can't sleep, headache, G.I. upset.

She often seeks a physical explanation for her distressing emotional state.

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moderate to severe anxiety...

Mellaril helps control the most frequent symptoms: marked nsion, agitation, apprehension, restlessness, hypermotility Mellaril often alleviates anxiety-induced somatic complaints Mellaril frequently helps strengthen emotional resources Mellaril helps the patient maintain alistic contact with environment, closer armony with family

ontraindications: Severely depressed or omatose states from any cause, and in ssociation with or following MAO inhibi- rs; severe hypertensive or hypotensive eart disease.

recautions: Hypersensitivity reactions e.g., leukopenia, agranulocytosis) and nvulsive seizures are infrequent. Pig- ientary retinopathy has been observed here doses in excess of those recom- ended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

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68-115

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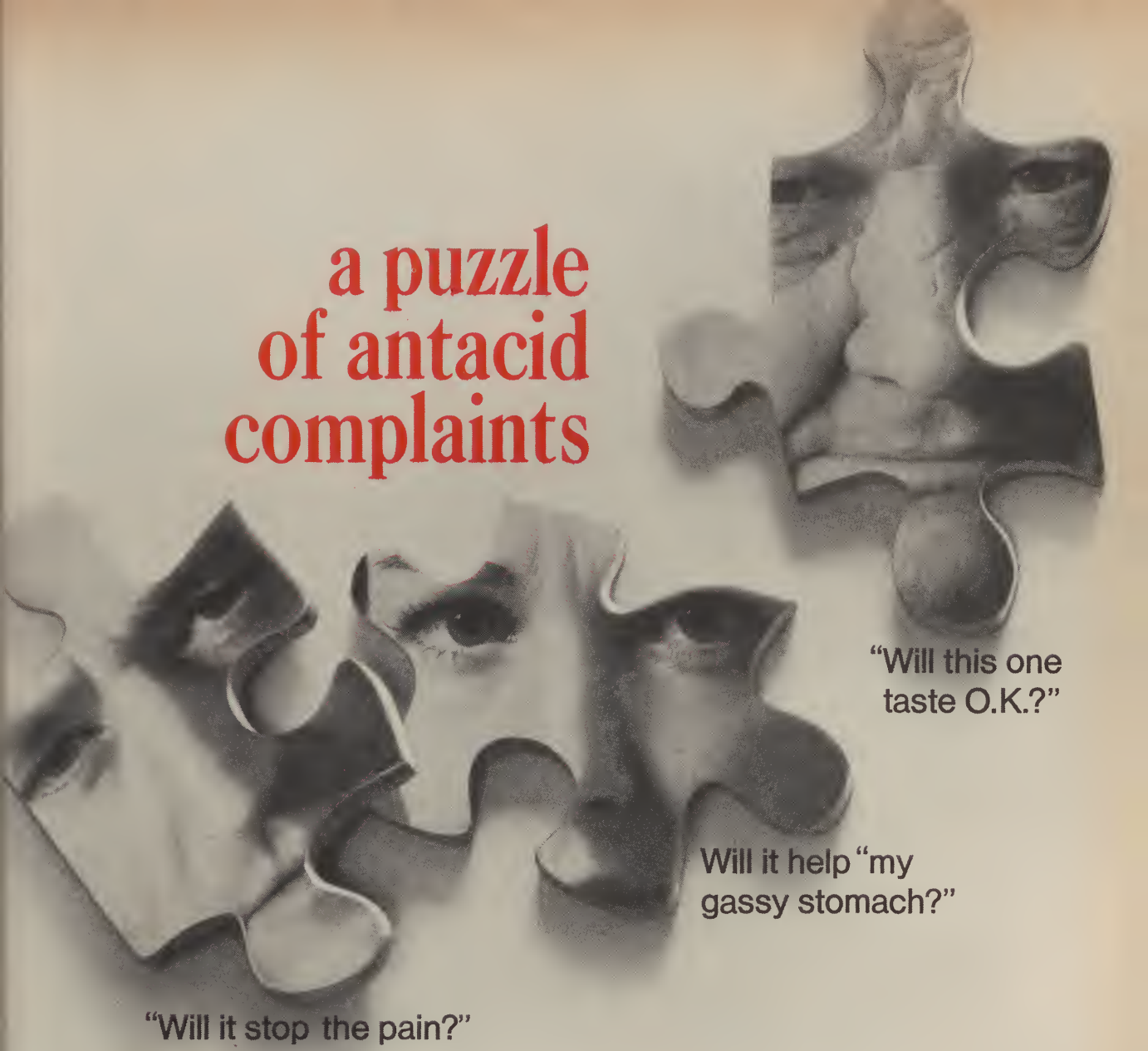
Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

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Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rowls, W., et al.: Med. Times, 87:818, 1959.

6/67 Q-706A



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in 87.5% of 104 patients after a total of 20,459 documented days of therapy.[2]

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg.
Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

References: 1. Hoon, J.R.: Arch. Surg. 93:467 (Sept.) 1966.
2. Danhof, I.E., Personal communication.

Stuart
Division/Pasadena, Calif.
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For a cold, NTz® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTz is well tolerated but overdosage should be avoided.

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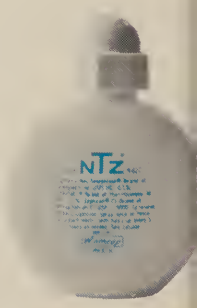
Supplied: NTz Nasal Spray, plastic squeeze bottles of 20 ml.; NTz Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

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State of Maryland
Department of Health
WILLIAM J. PEEPLES, MD, MPH, COMMISSIONER

Seminar on Quality Control in Clinical Chemistry

To insure reliable laboratory results in clinical chemical tests, the Biochemistry Division of the Bureau of Laboratories maintains routinely an internal quality control program including continued examination of known standards. In addition this Division participates in the proficiency testing conducted as part of the "National Laboratory Improvement Program" by the Medical Laboratory Section, National Communicable Disease Center, Atlanta, Georgia. To assist the private and hospital clinical laboratories in Maryland to maintain a continuously high level of performance, a two-day seminar will be held in May, on *Quality Control in Clinical Chemistry.*

Highlights

Laboratory Diagnosis of Cytomegalovirus Infection

The Virology Division of the Bureau of Laboratories now offers a new virus diagnostic service, i.e., the isolation and serologic testing of cytomegalovirus, the agent of cytomegalic inclusion disease (CID). The disease occurs primarily in the newborn. Generalized infection in the fetus during gestation will result in mental retardation, microcephaly, cerebral calcifications or, in some cases, death soon after birth.

It is possible to diagnose cytomegalovirus infection by serological examinations of blood from newborn infants. The virus can be isolated by human tissue-cell cultures of clinical material from these infants. Ten to fifteen days are required to perform the serologic test on serum, and at least one month to isolate culturally and finally identify the cytomegalovirus.

Research at some centers in the United States is being directed at identification, in tissue taken from the scalp of the fetus, of the "heavy" Immune globulins M, which do not pass out of the placental barrier.

Physicians Asked to Assist in Drug Economy

A list of some commonly prescribed brand name drugs and their generic equivalents, together with comparative wholesale prices, was recently sent to all physicians. The covering letter suggested that physicians consider prescribing the less expensive drugs when clinical efficacy is believed comparable to advertised brands. Pharmacists were also asked to cooperate in the effort to economize on this phase of the Medical Assistance Program.

Payment for Special Services in Nursing Homes Curtailed

Payment for physical therapy, speech therapy and podiatry services to Medical Assistance patients in nursing homes after February 1, 1968, has been eliminated, an action necessitated by the total depletion of budgeted funds. Some nursing homes offer these services as part of institutional care, and in some counties, services are provided through local health departments. The facilities of the Chronic Disease and Rehabilitation hospitals are available in cases where there is real promise of rehabilitation.

Lab Training in Medical Mycology

A recent workshop in identification of medically significant fungous organisms (medical mycology) was held by the Bureau of Laboratories, in conjunction with faculty specialists from the National Communicable Disease Center, Atlanta. This specialty course was given only to laboratory workers in Maryland who are actually engaged in medical mycology laboratory work.

VD Workshop for Public Health Nurses

The Divisions of Communicable Diseases, Nursing, and Health Education recently conducted a venereal disease workshop for public health nurses in Baltimore. The objectives were to provide current information on the status of venereal diseases and to establish guidelines for cooperation between nurses, venereal disease investigaters and health department clinicians. Enrollment was limited to a maximum of three nurses from each county.

REPORT OF THE AD HOC COMMITTEE FOR THE STUDY OF PKU LEGISLATION

I. *Purpose*—To study and make recommendations concerning the advisability of amending or repealing the existing PKU law.

II. *Approach*—A. Four meetings were held with persons deemed knowledgeable with the problem:

(1) Dr. Benjamin D. White, Director, Bureau of Preventive Medical Services

(2) Mr. Harry Penn, Administrator, Prince George's County General Hospital

(3) Dr. Samuel P. Bessman, Professor of Pediatrics, University of Maryland

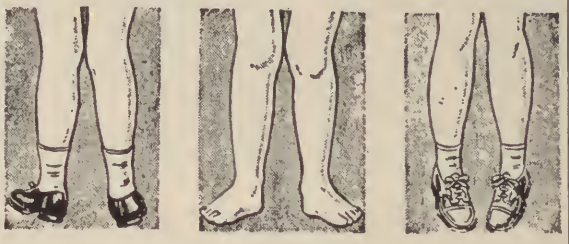
(4) Mr. Morris Scherr, Maryland Association for Retarded Children

B. A letter to administrators of general hospitals in Maryland requesting information as to whether any problems have arisen as a result of the law.

C. Requested an interpretation from the office of the Attorney General of the legal responsibility of the hospital in the event of follow-up failure.

III. *Results*—Dr. White provided the Committee with a history of PKU testing in Maryland. Originally, it began as a pilot program; statewide voluntary screening was approved by the Academy of General Practice, Academy of Pediatrics, Ob-Gyn Society, Maryland Pediatric Association, and Maryland Hospital Council. The Medical and Chirurgical Faculty did not take a stand and approved only that portion pertaining to an educational program for the public and physicians. Mr. Harry Penn felt that the real problem is not the testing but the placing of the legal responsibility on the hospital administrator. Although the hospital now bears the responsibility, it does not have the authority to enforce a follow-up. Dr. Samuel Bessman felt the PKU law is premature. Although he feels testing should be done, it should be voluntary. He questioned the efficacy of therapy and felt that mandatory testing (and subsequent mandatory treatment) was stultifying to research at this time. He believes strongly that PKU legislation should be repealed. Mr. Morris Scherr stated his association initiated legislation because no stand was taken by Med-Chi and proceedings also served to stir up interest in the legislature concerning mental retardation. The Maryland Association for Retarded Children Board of Directors is firmly committed to the law as it is at present. The Association would give consideration to repeal if it were proven that a hardship on persons or groups resulted, and that funds were unnecessarily expended. If continued on a voluntary basis, they would want assurance

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that the program continue as presently operated.

There are 45 general hospitals in Maryland. Of these, 14 responded to our inquiry. In general, the hospitals report that they are not experiencing hardship in implementing the law. The Baltimore City Health Department experienced a drop in the number of cases referred by hospitals for follow-up after the amendment of June 1, 1967. The amendment spells out what the hospital should do if the child leaves the hospital before a satisfactory test has been performed: i.e., the institution shall notify the parents of the infant in writing advising them to have the test performed by the private physician or local health department.

An inquiry was sent to the office of the Attorney General requesting an interpretation in those instances where contact of the parents was unsuccessful. The response by Mr. Louis E. Schmidt, Special Assistant Attorney to the Maryland State Health Department, is quoted in part—"There can be no doubt that the institution 'shall cause' to have administered the PKU test or determine that a 'satisfactory test' has been performed . . . The use of the word 'shall' in the statute indicates that the statutory provisions are mandatory and not discretionary. Therefore, no discretion appears intended in the administration of the PKU test. Thus, the institution must make certain that a satisfactory test is performed except when religious objection is raised."



IV. *Conclusion and Recommendations*—It is the opinion of the Committee that:

A. PKU testing of the newborn is necessary and desirable.

B. PKU testing of the newborn is a measure of good medical practice in our community today.

C. That a hardship has resulted from implementation of the present law has not been substantiated.

D. The law should be a matter of deep concern to the medical community in that it serves as a precedent for similar future legislation. All of us strive for good medical care for our patients. To be ordered to do so by a state law is an insult to our cumulative medical intelligence.

E. In spite of our strong feelings against medical legislation, we cannot foresee repeal of the PKU law at this time. We feel that if hardship cannot be proven it is most unlikely the law would be repealed on principle. Two amendments seem warranted, however:

(1) Discretion should be given the hospital administrator who in certain instances finds it impossible to locate the parent. Involvement of the parent in the follow-up process should be seriously considered.

(2) Mandatory screening should not mean mandatory treatment. This will permit further experimentation and research to continue.

F. Ferric chloride testing on PKU should be continued in the physician's office in addition to the Guthrie test in the hospital. Many physicians have discontinued this procedure since enactment of the law.

This report respectfully submitted, November 30, 1967

Raymond L. Clemmens, MD
Murray M. Kappelman, MD
Joseph J. McDonald, MD
Robert E. Yim, MD, Chairman





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Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

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Department of Mental Hygiene

ISADORE TUERK, MD, COMMISSIONER
KURT GORWITZ, ScD, STATISTICS DIRECTOR

ON BALTIMORE'S MENTAL HEALTH PROBLEMS AND NEEDS

The continuing increase observed for some time in the number of admissions to Maryland's mental hospitals is primarily related to the growing demand for inpatient treatment by Baltimore City residents. While admission rates have traditionally been higher in the city than in other areas of the state this gap, as shown in the following table, has widened noticeably in recent years.

ADMISSION RATE*

Fiscal Year	Total	Baltimore City	Four Suburban Counties	Nine Eastern Shore Counties	Ten Other Counties
1967	306.7	643.1	171.4	297.9	169.9
1966	279.0	516.9	166.7	306.8	186.6
1965	249.3	457.0	150.8	295.0	156.8
1964	234.7	415.3	143.1	267.7	161.5
1963	221.4	377.7	137.2	275.3	139.2

**Number of admissions per 100.000 estimated population in specified area and year.*

Baltimore, like most urban centers, has a population virtually stationary in size which accounts for a declining proportion of total state residents. While 28.8% of Maryland's population lived in the city at the beginning of 1963, this had decreased to 25.3% by 1967. Despite this, 48.5% of the 7,257 state hospital admissions in 1963 and 53.0% of the 11,091 admissions in 1967 lived within the city confines. A similar upward trend has been observed in psychiatric outpatient units.

An earlier report,* based on data from the Maryland Psychiatric Case Register, showed that major variations existed also within Baltimore. This study reported that admissions to inpatient care during a three-year period (1961-1964) ranged from 0.42% of the total population in outlying areas to 8.16% in inner city tracts. These data reflect a general pattern of rising health needs produced by the changing composition of Baltimore's population. It is a result of the mass exodus of white middle-class residents to the suburban counties and a concomitant increase in the number of poor, culturally deprived, community dependent city residents.

One effort to reduce the need for hospitalization has involved the establishment of a comprehensive community mental health center covering an area south and west of downtown Baltimore. However, this center when fully operational can have only limited impact since it will serve less than 10% of the city's total population. Clearly, concentrated endeavors to resolve these problems must involve the development of other centers together with the integration and coordination of mental health and other community agencies and programs serving urban inner core areas.

*Klee, Gerald D., Bahn, Anita K., Spiro, Evelyn and Gorwitz, Kurt; An Ecological Analysis Of Diagnosed Mental Illness In Baltimore, Psychiatric Research Report 22, American Psychiatric Association.

The Cost of Hospitalization

The average total cost of treating a patient in Maryland's psychiatric hospitals from admission until ultimate discharge decreased 40% during the past 12 years and is now at its lowest level. As indicated in the following table, while average daily per patient expenditures more than tripled during this period, increased turnover resulting primarily from shortened periods of hospitalization produced a continuing decline in the cost per live discharge.

FISCAL YEAR	AVERAGE NUMBER OF HOSPITALIZED PATIENTS	TOTAL PATIENTS TREATED	LIVE DISCHARGES	DAILY PER PATIENT COST	COST PER PATIENT TREATED	COST PER LIVE DISCHARGE
1956	9,530	15,019	2,511	$ 3.38	$ 785.55	$4,698.58
1960	8,576	16,268	3,953	5.08	977.09	4,021.09
1964	8,035	19,424	7,197	7.05	1,067.37	2,880.74
1968 (est.)	7,758	23,387	11,275	11.04	1,340.54	2,780.60
PERCENT CHANGE (1968 vs. 1956)	—18.6	+55.7	+349.0	+226.6	+70.6	—40.8

Hospital expenditures increased an average of 9% annually between 1956 and 1968. In terms of daily cost per patient, this represents a total rise of 226.6% (from $3.38 to $11.04). However, during the same time period, the number of patients treated each year rose 55.7% (from 15,019 to 23,387) and live discharges increased 349.0% (from 2,511 to 11,275) while the average daily number of patients declined 18.6% (from 9,530 to 7,758). In 1956 an average expenditure of $4,698.58 was required to produce each of that year's 2,511 discharges. It is estimated that the average cost for each of the 11,275 discharges in the current year will be $2,780.60.

While these data reflect a general reduction in the length of hospitalization of virtually all diagnostic categories of patients, they also relate to the expanding use of state hospitals for intensive, short term treatment of acute nonpsychotic disturbances. Individuals with diagnoses such as alcoholism, brain syndromes, psychoneurotic disorders and personality disturbances now account for a majority of the patient population and for more than two-thirds of all admissions. Among those currently accepted for hospitalization, more than half are released within six weeks and better than 90% are returned to the community within one year.

These statistics indicate that Maryland's mental hospitals are in a state of rapid transition. The long-term chronically ill no longer predominate and their proportion of the patient population can be expected to continue declining. Concomitantly, an increasing percentage of all patients will be acutely ill and will be hospitalized only for brief periods. As this trend continues, the average daily per patient cost must be expected to rise further, ultimately approaching comparable figures for general hospitals. They can also be expected to produce further increases in the number of patients treated and an additional appreciable decline in the total cost of each treatment episode.

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MARYLAND HEART CALENDAR

The following meetings have been scheduled by the Heart Association of Maryland and the Maryland Heart Chapters.

APRIL

Wednesday-Friday—17-19th

Annual Meeting of the Medical & Chirurgical Faculty, The Alcazar, Baltimore.

Thursday—18th

Executive Committee Meeting, 4 P.M., Heart Offices HAM

Saturday-Sunday—20-21st

Regional Organizational Meeting — Arlington, Va. AHA

Monday-Tuesday—22-23rd

Regional Affiliate Directors Meeting, Arlington, Va. AHA

Sunday-Saturday—21-27th

VIII Inter-American Congress of Cardiology, Lima, Peru

Thursday-Friday—25-26th

4th Annual Convention of the Maryland League for Nursing, Commander Hotel, Ocean City, Maryland.

MAY

Wednesday—8th

Annual Flower Mart — Mt. Vernon Place, Baltimore

Thursday—16th

Executive Committee Meeting, 4 P.M., Heart Offices HAM

Tuesday—21st

H. A. Western Maryland Executive Board Meeting, 6:30 P.M. HAWM

Wednesday—22nd

Montgomery County Cardiac Symposium MCHA

Thursday-Friday—23-24th

Maryland Public Health Association Annual Meeting, Sheraton-Belvedere Hotel, Baltimore

Monday-Wednesday—27-29th

CHAPMS Spring Meeting, Great Oak Lodge & Yacht Club, Chestertown, Md. HAM

JUNE

Friday-Saturday—7-8th

AHA Board of Directors Meeting—New York City AHA

Thursday—13th

Heart Assn. of Md., Board of Trustees Meeting HAM

Friday-Sunday—14-16th

"Weekend With Medical Personnel" — Heart Association of Western Maryland HAWM

Thursday—20th

Annual Meeting, Heart Assn. of Western Md., 6:30 P.M. HAWM

Friday-Sunday—21-23rd (tentative)

Weekend With Doctors — Western Maryland College, Westminster, Maryland HAM

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Indications For mixed infections which are more susceptible to the combination than to either agent alone. These may include susceptible gram-positive and/or gram-negative mixed infections. Not recommended in the treatment of infections expected to respond to full therapeutic doses of the antibiotic or sulfonamide alone.

Contraindications Known hypersensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, in premature or in newborn infants during first week of life.

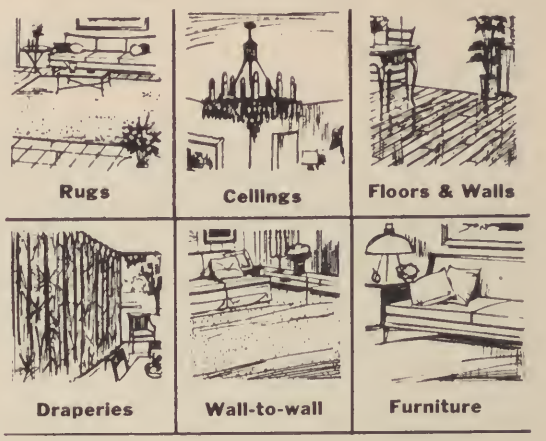
Warnings As with other forms of sulfonamide therapy, use only after critical appraisal in patients with liver or kidney damage, urinary obstruction, or blood dyscrasias. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests when used intermittently or for long periods.

Precautions, Side Effects Use sulfonamides with caution in patients with a history of allergy, including asthma. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent; if encountered appropriate countermeasures (e.g. epinephrine, steroids, etc.) should be administered and the drug withdrawn. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. In prolonged therapy, or when high dosage is used, maintain an alkaline urine. If oliguria occurs, discontinue therapy. Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin; generally improved by reduction of dosage.

If overgrowth of nonsusceptible organism occurs, withdraw the drug and institute appropriate treatment.

Adverse Reactions Sulfonamide therapy may be associated with headache, nausea, vomiting, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, urticaria, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.. 803446

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Critical Nurse Shortage Worsens

The registered nurse — that angel in the starched white uniform—is becoming a rare bird.

Not only are there over 100,000 too few of her today, but in about three years it is estimated there will be an even more critical shortage of nearly 200,000 nurses.

A Health Insurance Institute review of national statistics indicates that the shortage blankets the country.

According to the U. S. Public Health Service, the nation has only about 80 per cent of the registered nurses it needs to help care for the sick and injured.

In some areas the shortage is so acute that hospitals have been forced to limit their services. In New York City's huge Bellevue Hospital a single registered nurse is sometimes responsible for 300 patients on seven floors.



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Not Enough

Government figures show approximately 750,000 registered nursing positions in the United States—a number that many agree could not provide the best of care even if completely filled.

As 1967 began only 640,000 nurses were practicing, about one-fourth of whom worked part time.

The latest comprehensive government survey on nursing needs highlighted the fact that by 1970, 850,000 full-time R. N.'s would be needed to provide adequate care for the increased population.

Even this estimate may have to be revised. It was made before the full impact of benefits under the government-sponsored Medicare and Medicaid programs could be calculated.

At present growth rates, only 680,000 nurses will be available in 1970 to fill the nation's minimum need of 850,000 at that time.

Many officials concerned with the shortage believe the answer is a better income and better working conditions.

Although wages have recently been increased in a few parts of the country, the average is still only a little over $5,000 a year. In some sections it is much lower.

And working conditions today, necessarily because of the usual staff and nursing shortages, are not what they could be in most hospitals.

For instance, when a hospital is understaffed, a nurse must often do work that has little to do with her specialized training, such as cleaning equipment, preparing medications that the pharmacist should be preparing, running errands, filing medical records, and the like.

Dissatisfaction

When all these unprofessional chores are finished, studies show that nurses have time left to employ only about 25 per cent of their professional skills in the day-to-day care of patients.

Often, a nurse's dissatisfaction with working conditions is reflected in her frequent job shifting. A nurse's turnover rate is about 70 per cent, a figure exceeded only by waitresses.

Another way to relieve the shortage, many experts believe, is to attract more members of minority groups to the profession. For example, although Negroes are accepted in most nursing schools, they still make up only three per cent of the country's enrollment, exactly the same as 20 years ago.

A Public Health Service report noted: "The small proportion (of Negroes in nursing) is probably due both to discrimination in admissions and to inadequate secondary education."

In some areas, these problems are being overcome. Recently the Sealantic Fund, established by the late John D. Rockefeller, Jr. granted $140,000 to six colleges to encourage their nursing schools to recruit and tutor interested Negroes.

The shortage has had its bizarre effects, too.

According to the Institute, one medium-sized New York City medical center spent over $150,000 on classified ads alone in its search for nurses.

A hospital on Long Island rented a blimp to cruise over Manhattan with the words "Nurses. Call This Number: . . . ," painted in 10 foot high letters on its sides.

The phone number was that of the hospital, and the intention was recruitment. It didn't work out all that well.



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AMA Establishes Approval Program for Certified Laboratory Assistants

The American Medical Association's Council on Medical Education has established, in cooperation with the American Society of Clinical Pathologists, and approval program for certified laboratory assistants.

It is the ninth health occupation for which the AMA now maintains approval programs to assure that training standards acceptable to the medical profession are being met.

Before the AMA established the approval program last December, schools for certified laboratory assistants were approved only by the American Society of Clinical Pathologists.

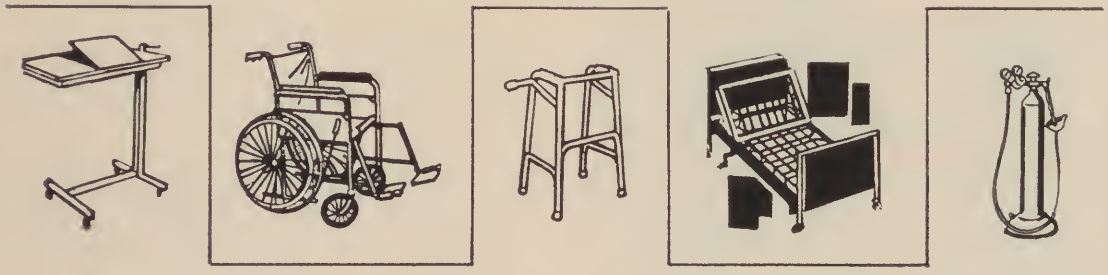
The original certification program, aimed at providing standardized training and national certification under medical auspices, was initiated in 1963 by the ASCP and the American Society of Medical Technologists.

Upon completing an accredited 12-month course of hospital or laboratory school training and passing an examination, graduates are designated as certified laboratory assistants. To meet the increased demands for laboratory service, it is estimated that 100,000 certified laboratory assistants will be needed by 1975.

The current list of AMA-approved schools for laboratory assistants, as well as lists of other AMA-approved or accredited schools—cytotechnology, inhalation therapy technician, medical record librarian, medical record technician, medical technology, occupational therapy, physical therapy and x-ray technology—may be obtained by writing the AMA's Department of Allied Medical Professions and Services.

A six-page pamphlet, "A Career for You as a Certified Laboratory Assistant," may be obtained by writing the Secretary, Board of Certified Laboratory Assistants, 445 N. Lake Shore Drive, Chicago, Illinois 60611.

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COMPONENT MEDICAL SOCIETIES

BALTIMORE CITY DENTAL SOCIETY JOINT MEETING WITH THE BALTIMORE CITY MEDICAL SOCIETY

Wednesday, May 8, 1968, 8:00 P.M.
Speaker: Leonard M. Estad, PhD, President, Gallaudet College, Washington, D. C.
Subject: the Story of the Congenital Deaf Child from Cradle to College
Place: 1211 Cathedral Street, Baltimore, Md.

* * *

The monthly meeting of the Board of Directors of the Baltimore City Medical Society was called to order by Frank Kaltreider, MD, on March 12, 1968 at 1211 Cathedral Street. Two members of the Board were absent.

The minutes of the February meeting were approved as circulated.

S. H. Barranco was recommended for emeritus membership.

The resolutions to be presented before the House of Delegates at the forthcoming meeting were read and discussed in detail. The Board is in favor of the following resolutions:

1. **Condemning attempts by insurance carriers to determine qualifications of physicians and requesting that such carriers amend their regulations to prevent this.**
2. **Endorsement of retention of the present board of post-mortem examiners as a separate government agency.**

The Board of Directors feels they cannot recommend the following resolutions:

1. Authorizing the Council, in special instances, to waive by-laws requirements that physicians defense be granted only if dues are paid by January 31st of the year in which the event occurred.
2. Urging physicians to charge their usual, customary and reasonable fees under Public Law 89-97, Title 18 of the Social Security Law, and not to complete assignments in this regard.

The Board of Directors charged Dr. Kaltreider to select a committee to examine in detail the proposal of Faculty position taken in 1962 regarding incorporation of a self-employed person.

It was the Board's recommendation that this committee look into the corporate practice of medicine from the moral, ethical, and economical point of view and report to the Board at the April 5 meeting.

The next item on the agenda was a report by H. Moses, MD, Chairman of the Program Committee. It was Dr. Moses' opinion that the recent policy of the Medical Society meeting in various community hospitals has not been successful. He pointed out that the attendance of the last meeting at Church Home and Hospital was poor and that there is difficulty in arranging such programs within the individual hospitals. He suggested that the meetings be changed back to the Faculty building on Cathedral Street. The Board discussed the problem briefly and decided to follow his suggestion.

The Board of Directors discussed and reviewed Senate and House Bills. The Board feels the following House Bills should be opposed by the Baltimore City Medical Society:

1. *House Bill* 273—authorizing the Governor to do certain necessary things to develop a mechanism for comprehensive Health planning.
2. *House Bill* 274—providing that a license to open or continue a hospital not be issued unless it conforms to the Comprehensive Health Plan.
3. *House Bill* 275—requiring the State Health Department to develop, study and revise, from time to time, a cost procedures and cost standards program and a plan relating to services in the hospital.
4. *House Bill* 1022—providing that pharmacist may substitute generic drug for one prescribed by physician under certain circumstances, and compilation of list of drugs which can be furnished under generic name.
5. *House Bill* 1112—requiring administering of Chloramphenicol and other toxic drugs be administered only to patients admitted to licensed hospitals, requiring certain tests and other regulations concerning this drug.
6. *Senate Bill* 372—provide for establishment in State Department of Health of a birth defects institute (This Bill tends to restrict research as it is now worded).

The Board is in favor of the passage of *House Bill 21*—establishing commission on medical discipline; and *House Bill 88*—having to do

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with abortion laws; *Senate Bill 50*—which could make it unlawful to sell, transfer or barter glue and glue products; *Senate Bill 78*—increasing the number of medical scholarships and amending provisions for admission by the School of Medicine; and *Senate Bill 75*—implied consent.

The Woman's Auxiliary plans for observance of Doctors' Day to be held on March 30th were reported to the Board of Directors.

A report of the election of Delegates and Alternates at the March 1st meeting was presented.

It was recommended that Dr. Kaltreider form a committee to examine the possibility of obtaining a full-time Executive Secretary for the Baltimore City Medical Society.

Arthur E. Cocco, MD
Journal Representative

SECTION ON REHABILITATION

Wednesday, May 15, 1968, 8:00 P.M.
Panel Discussion: Alexander S. Dowling, MD, John Gessner, MD, and Francis Borges, MD
Subject: What Montebello Can Offer Your Patient
Place: Montebello State Hospital
Julian Reed, MD, *Chairman*, J. Michael Coyne, MD, *Secretary*

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AMA's 11-Point Statement of Responsibilities

The American Medical Association has issued an 11-point statement regarding the purposes and responsibilities of the AMA. Broad initiative in advancing health care for everyone is detailed in the expanded statement which has been adopted by the AMA's House of Delegates.

The statement declares it is the responsibility of the AMA, as the representative of the American medical profession, to continue to foster the advancement of medical science and the health of the American people and to discharge that responsibility through the following means:

1. By Encouraging the advancement of medical knowledge, skills, techniques and drugs; and by maintaining the highest standards of practice and health care.
2. By creating incentives to attract increasing numbers of capable people into medicine and the other health-care professions.
3. By advancing and expanding the education of physicians and other groups in the health-care field.
4. By motivating skilled physicians who have the art of teaching to apply themselves to developing new generations of excellent practitioners.
5. By fostering programs that will encourage medical and health personnel to serve voluntarily in the areas of need for medical care.
6. By developing techniques and practices that will moderate the costs of good medical and health care.
7. By seeking out and fostering means of making all health care facilities—physicians' offices, hospitals, laboratories, clinics and others—as efficient and economical as good medical practice and attention to human values will permit.
8. By combining the utilization of the latest knowledge for prevention and treatment with the vital healing force of the physician's personal knowledge of and devotion to his patient.
9. By maintaining the impetus of dedicated men and women in providing excellent health care by preserving the incentives and effectiveness of unshackled medical practice.
10. By maintaining the highest level of ethics and professional standards among all members of the medical profession.
11. By providing leadership and guidance to the medical profession of the world in meeting the health needs of changing populations.

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Abramson, Daniel J., M.D., 1100 22nd St., N.W., Suite T11, Washington, D. C. 20037

Abreu, Pedro J., M.D., 5901 Edmond, Apt. 230, Waco, Texas 76710

Abuelo, Julian G., M.D., 6124 E. Pratt St., Baltimore, Md. 21224

Adamo, Ido, M.D., C. T. Perkins State Hospital, Jessup, Md. 20794

Aguilar, Armando P., M.D., 207 S. Elm Ave., Kankakee, Ill., 60901

Aleman, Juan F., M.D., 4640 Lincrest Dr., N., Jacksonville, Fla. 32208

Amar, Leroy J., M.D., 8787 Shoreham Dr., Los Angeles, California

Amor, Ramon L., M.D., 701 Antrim Dr., Apt. 1-A, Newport News, Va. 23601

Anderson, Robert D., M.D., 2727B W. Court Rd., Aberdeen Proving Ground, Md. 21005

Area, Leandro, M., M.D., 4316 Carlyn Springs Rd., Arlington, Va., 22203

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Armitage, David T., M.D., 1808 Metzerott Rd., Adelphia, Maryland 20783

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Azadi, Massoud, M.D., 4537 Manorview Rd., Baltimore, Md. 21229

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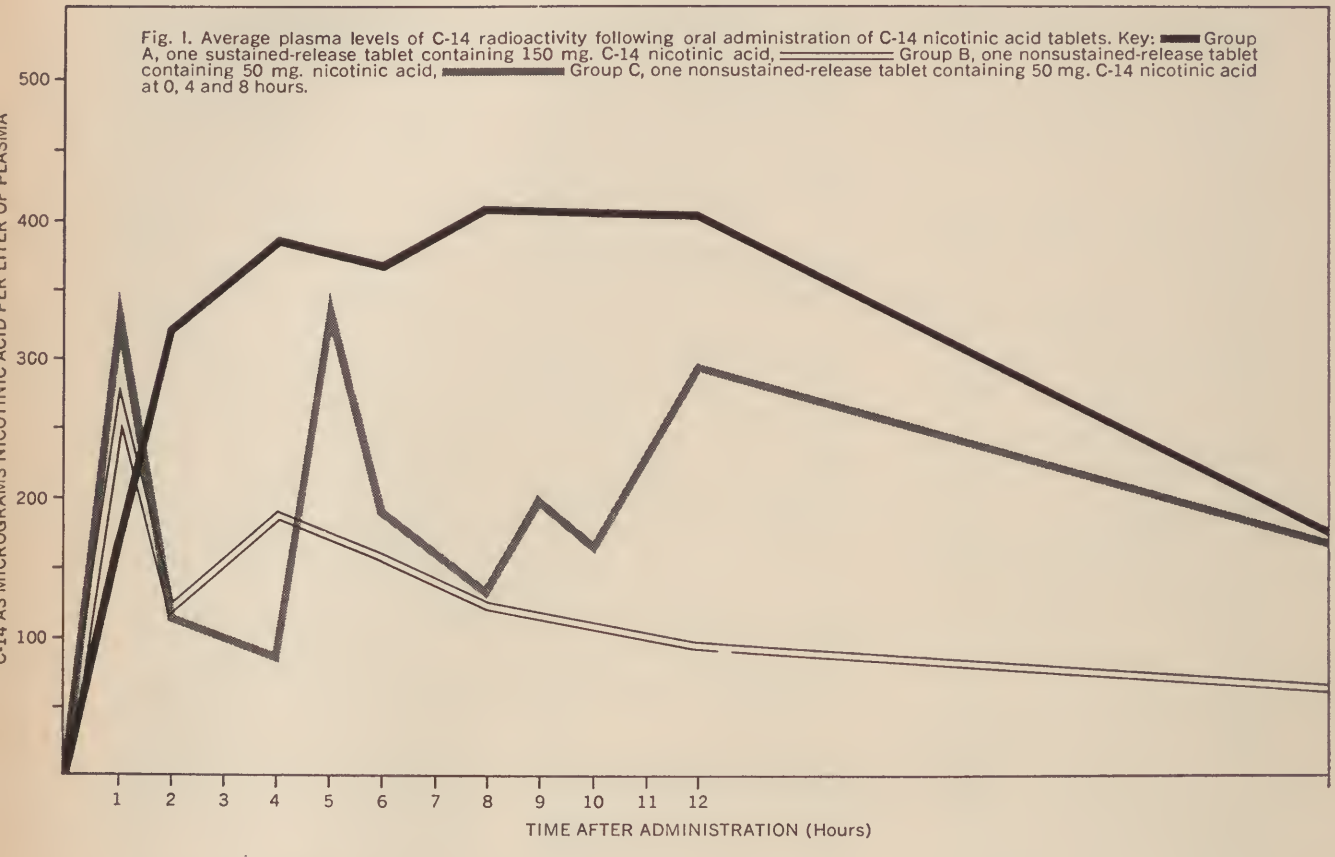
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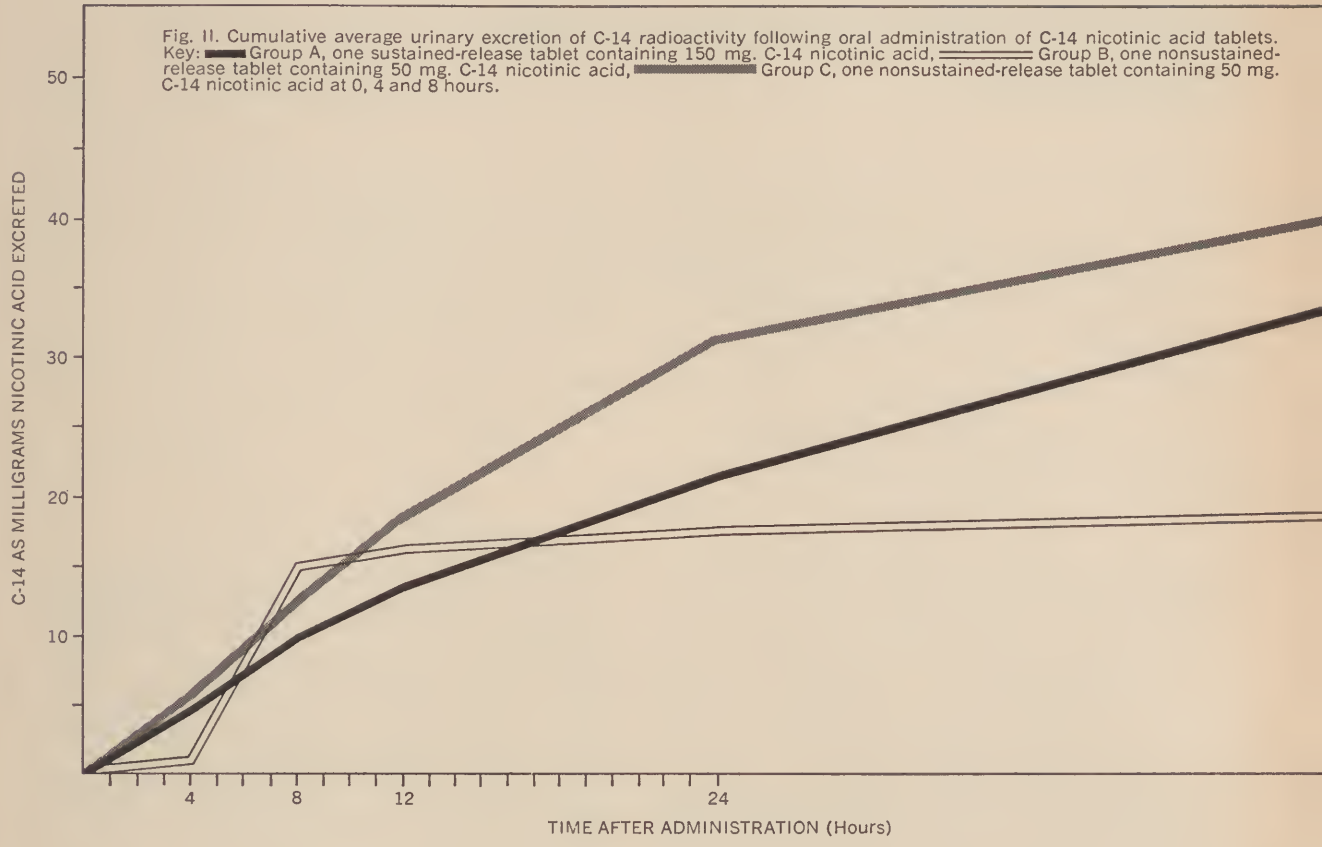
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

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References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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Osteoarthritis

Osteoarthritis, one of the oldest diseases known to man, is in many respects scarcely less an enigma today than when first described. In fact, it is a growing problem in management, with increasing longevity of the population.

B. STANLEY COHEN, MD

Recent studies in Britain, of 1098 males and 1198 females, revealed 52% of the men and 51% of the women with moderate to severe X-ray stigmata of osteoarthritis.[1] In general, there was a low complaint rate, but in the age group over 55 years, incapacity was associated with the osteoarthritis.

The first cycle of the United States Health Examination Survey, between 1959 and 1962, seeking to develop statistics on the health status of the population, disclosed an incidence of osteoarthritis of 37%.[2] The incidence increased, as might be expected, with advancing age, from 4% in the age group 18-24 to 85% in the age group 75-79. Studies were based on history, physical examination, bentonite flocculation studies, and graded X-rays on the hands and feet. The results indicated that 23% of those with osteoarthritis had moderate or severe involvement. No pattern of racial, regional, or urban-rural differences was noted. The incidence among craftsmen, miners, and construction workers, however, was high.

The etiology of the process is still not well established but the disease evidently results from a combination of factors. Indeed, it is not a single process, but as Kellgren has pointed out, most likely a form of "articular failure which, like cardiac or renal failure, may result from a variety of processes."[3] Genetic or environmental factors appear to determine which joint or joints become affected, and local articular processes determine the type and extent of involvement.

Types of Involvement

Secondary degenerative joint disease follows trauma and excessive mechanical stress, particularly evident in weight-bearing joints. Primary, or idiopathic arthritis, seems to follow genetic patterns. Sokoloff has demonstrated osteoarthritis in mice to be a genetically governed disease involving multiple genes, with an overall recessive behavior.[4] The studies of Heberden's nodes have shown that degenerative joint disease in man is genetically influenced.[5] Heberden's nodes have been found to occur twice as often in the mother and three times as often in the sisters of patients than in the general population. The primary generalized osteoarthrosis described by Kellgren[6] also follows an inherited pattern, associated with Heberden's

**The Arthritis Foundation (Maryland Chapter, 12 W. 25th St., Balto., Md. 21218) is arranging a series of articles by experts on arthritis to appear from time to time in Rehabilitation Notes.*

nodes. The studies suggest a genetic pattern which is dominant in females and recessive in males. Environmental factors may bring out a hereditary predisposition for Heberden's nodes in males. The health survey pointed up a higher than expected incidence of osteoarthritis in the hands of craftsmen, who subject their hands to long periods of stressful activity.

The development of changes in one or several joints, usually in the weight-bearing portions of the body, and without association with Heberden's nodes, can be shown to be associated with trauma and mechanical stress. Thus, the occurrence of osteoarthritis is seen in the lumbar spine in coal miners and others doing heavy labor;[7] osteoarthritis may develop in a single joint following severe trauma, with internal derangement; malum coxae senilis occurs in a hip previously involved by Legg-Calvé-Perthes disease or the site of congenital hip anomaly; osteoarthritis is seen in knees with mechanical derangement secondary to genu varus or valgus, with foot abnormalities and compounded by obesity.

Pathological Findings

Regardless of etiology, and in all joints, the pathological findings are essentially the same. Fibrillation and deterioration of the cartilage and overgrowth of juxta articular bone are the hallmarks. Subchondral sclerosis, cyst formation, and disorganization of the trabecular pattern are seen. There is general agreement that inflammatory changes, with synovitis, are not a component of uncomplicated osteoarthritis.[8] An exception is a recently reported form of osteoarthritic associated with a distinct inflammatory synovitis.[9] Here, in the proximal interphalangeal joints and the distal interphalangeal joints, in addition to cartilage destruction and osteophyte formation, were seen erosion of cartilage and juxta articular bone, and a synovium with villous hypertrophy resembling rheumatoid arthritis. Absence of involvement in other joints and negative tests for rheumatoid factor were noted. The authors have named the process "Erosive osteoarthritis."

Only a small portion of those with pathological lesions of osteoarthritis have symptoms. Osteoarthritis seems therefore to be predisposing toward, rather than the cause of symptoms. The painful episodes are related to ligamentous sprains and to traumatic synovitis following minor, sometimes trivial, injury to the joint. Joints subject to weight bearing or rendered more vulnerable to trauma by motion are most likely to be symptomatic. Lawrence has pointed out that the relationship of X-ray to symptoms is determined largely by the natural mobility of the joint. Thus, in the fingers, the association is greater in the proximal than in the distal joints.[1]

Diagnosis and Treatment

Symptoms are generally joint pain, on motion and weight-bearing; stiffness after periods of rest; and aching with inclement weather. The symptoms usually begin and progress insidiously and episodically. Additional symptoms may be related to impingement on adjacent structures. In cervical arthritis, root compression may result in pain radiating into the upper extremities; and impingement on the cord, or interruption of its circulation, may result in long tract signs, including spasticity and paraparesis. Costovertebral joint involvement may impinge on intercostal nerves, with symptoms simulating chest pain of other etiology. Patterns of referred pain may alter presenting symptomatology. Thus, arthritis of the hip may produce pain referred to the groin or medial aspect of the knee.

Examination reveals crepitation on joint motion, change in the shape of the bone, and limitation of joint motion. There may be muscle spasm or muscle atrophy in areas adjacent to the joint. Systemic symptoms, except in the case of the primary generalized form described by Kellgren, are not noted. Laboratory studies are of value only for the exclusion of other conditions. The synovial fluid is usually clear and viscous, with a normal mucin clot, and with a low white cell count.

Diagnosis may usually be confirmed by X-ray findings but the presence of X-ray evidence of osteoarthritis in the symptomatic patient does not necessarily mean that the symptoms are due to osteoarthritis. The generally low complaint rate associated with radiographic evidence of osteoarthritis requires that other systemic causes of symptoms be considered and excluded.

Management of the patient with osteoarthritis is determined by the specific joints affected, but generally involves certain basic principles. Treatment is directed at the removal of aggravating factors contributing to additional trauma, such as obesity, mechanical abnormalities, and postural faults. Postural correction may be accomplished by exercises, external support, and shoe modifica-

tions. Rest of the affected part represents an important phase of treatment. This may be accomplished by reducing or avoiding weight-bearing, or by the use of ambulatory aids such as canes, crutches, or occasionally, long-leg braces. Support in recumbency with a firm mattress and bedboard is helpful.

Relief of pain may be accomplished with analgesic medications, the most useful of which is aspirin. Dosage should be adequate. Small or erratic dosage is usually ineffective. Aspirin in the amount of 2.5—3.5 grams daily, in divided dosages, may be effective. Drugs with greater toxicity are not usually justified. Some patients, however, may be benefited by low dosage phenylbutazone[10] or indomethacin.[11] Muscle relaxants are of little value. Systemic steroids are rarely justified, particularly in the post-menopausal woman where the risk of osteoporosis is greater. Intra-articular cortico steroids have been found to be helpful in those cases with associated traumatic synovitis.

In many controlled studies, the placebo effect of drugs and physical agents has been shown to be considerable. Joint injection is a particularly successful form of placebo therapy. In one study, 11 of 18 patients with osteoarthritis of the knees experienced relief of pain and increase in function following intra-articular saline injection. Placebo tablets afforded relief in four of 19.[12]

Physical measures have a good deal to offer the arthritic. Heat affords temporary relief, and helps to relax muscle spasm and prepare for therapeutic exercise to follow. Moist heat, in the form of hot packs, is generally available and is effective. Short wave diathermy may be helpful in specific cases, as in the knees, and the use of ultrasound therapy has been helpful in affording relief in the painful hip. Paraffin immersion is particularly helpful for the small joints of the hand, is inexpensive and easily adapted to home use.

In addition to rest and measures for relief of pain, exercises are prescribed for the purpose of maintaining joint range of motion and avoiding or overcoming contractures. Normal power should be restored and maintained in the muscles about an involved joint. In the knees, particularly, progressive resistance quadriceps exercises are important. An adequate extensor mechanism helps protect the knee from further trauma. In arthritis of the lumbar spine, exercises to increase the power of the abdominal and back muscles are helpful. In cervical arthritis, traction, sustained or intermittent, may be useful in relieving root pain. Traction for the lumbar spine is generally ineffective compared with the cervical spine.

As in the management of rheumatoid arthritis, the program of heat and exercise should be individually prescribed, and should be one that can be carried on at home by the patient for long periods. The program should involve minimum expense and should be one which is acceptable to the patient over many months or years. Efforts should be made to encourage him and sustain his motivation, through regular re-evaluation and adjustment of the program.[13]

Surgical Treatment

In selected patients, where conservative medical management is unsuccessful, surgery may be required. Ideally, orthopedic procedures should be preventive measures, early in life, to correct such problems as scoliosis, and mechanical abnormalities of the hips, knees and feet.

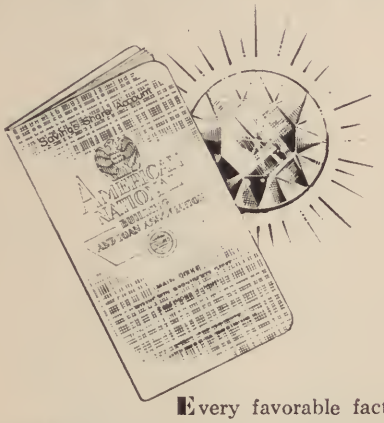
A number of procedures have been developed for the relief of pain and improvement of function in arthritis of the hip. Arthrodesis gives relief from pain, though at the sacrifice of mobility, and is useful in the younger active patient with unilateral disease and a mobile lumbar spine. Osteotomies, to change weight-bearing angles, and prosthetic replacement are successful in selected cases. A resection angulation operation, described some years ago, has been re-emphasized by Milch as a useful procedure.[14] Salvage procedures such as the Girdlestone and "hanging hip" operations are used to relieve pain in late cases where function has already been significantly impaired.

Osteotomy and other correctional procedures are useful in the knees and feet. Removal of bony spurs and foraminotomy have been helpful where spinal osteophytes encroach on neural structures. Anterior cervical fusion has gained prominence in recent years for cervical arthritis with segmental root compression and cervical spondylosis.

Summary

The general approach to the patient with symptomatic osteoarthritis calls for reassurance and emotional support; for measures to provide rest and relief of pain; for correction of mechanical factors which may result in the progression of arthritis; and for maintenance of mobility and optimum function. This may entail, under various circumstances, the use of drugs, physical therapeutic measures, braces and supports, and preventive and correctional surgery.

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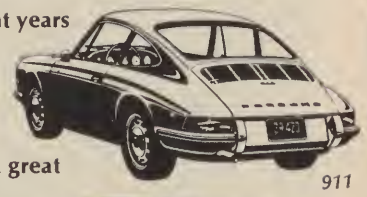
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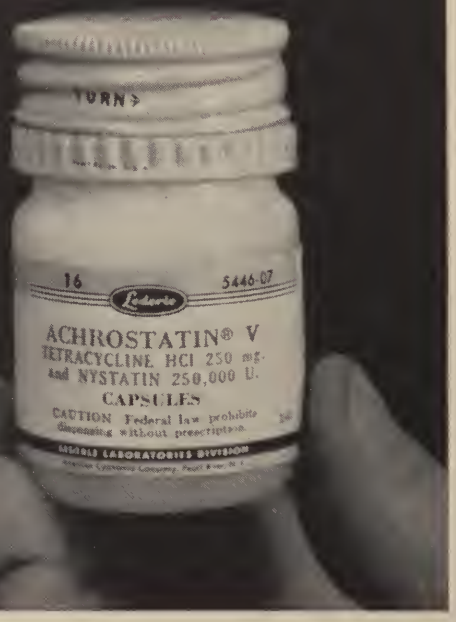
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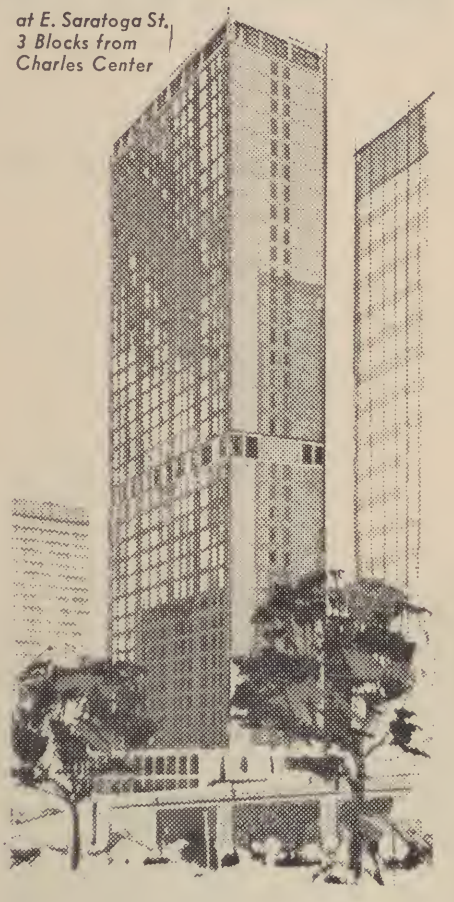
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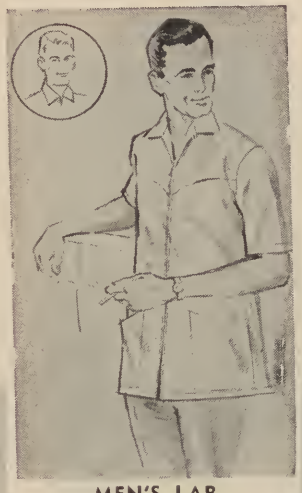
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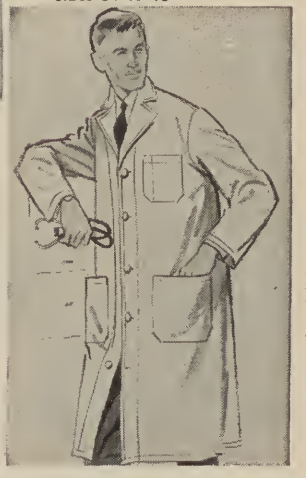
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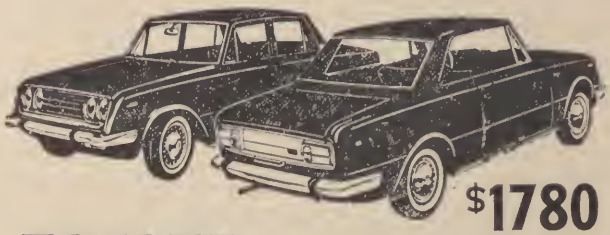
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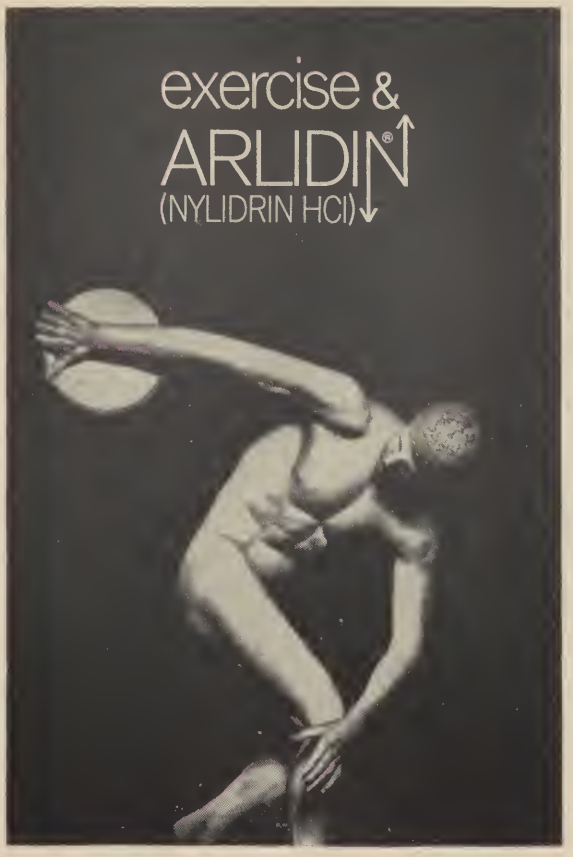
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Waldo B. Moyers, MD, of University Park, Maryland, died on December 9, 1967 after a long illness.

"Pop" as he was affectionately known to his many friends and colleagues, enjoyed a long career of distinction and service to humanity. It was during his early years as a school teacher he realized his true vocation to be that of a physician. He entered the University of Maryland School of Medicine and after graduation, elected to practice in Mount Rainier where he stayed until shortly before his death.

"Pop" exemplified the physician at his best. He was compassionate and kind. He understood people, recognizing their frailties and their foibles. He was sympathetic to their problems and always listened with a friendly ear, ready to assist in any way he could.

Within the profession, he was counselor and a friend. He assisted immeasurably in the revitalization of the Faculty during the 1950's, recognizing the responsibility of the profession in serving the public through an organized and knowledgeable organization.

His extensive work in the fields of medical planning, problems of the aged, social services and public welfare brought plaudits from several of Maryland's governors.

But he did not confine his activities to medicine and the related fields. He was active in churchwork at St. Andrew's in College Park; and his interest in civic affairs led him to the position of president of the Rotary (1958-1959) and member of the board of the Suburban Trust Company. He was a member of the Terrapin Club of the University of Maryland, the Mason Lodge of Mooresfield of West Virginia; and the Columbia Country Club.

His medical distinctions included being a Fellow of the American College of Physicians; a Fellow of the American College of Cardiology; an Instructor in Clinical Medicine at Georgetown University Hospital; a Diplomate of the American Board of Internal Medicine; President of the staff at Prince Georges General Hospital, Cheverly; Chairman of the Medical Examining Board of Selective Services. Also, he served on the boards of the Prince Georges Tuberculosis Association and the first Mental Hygiene Demonstration Clinic. He was a Fellow of the American Geriatric Society; and served on the Executive Committee of the Medical and Chirurgical Faculty, as well as serving in many other capacities with the Faculty.

"Pop" was instrumental in the formation of the Prince Georges County Heart Association and served as its first president. He was also president of the Prince Georges County Medical Society.

He is survived by his wife, the former Elinor Corell, a son, Deal, of Richmond, Va., and two sisters, Mrs. Leonard Hollen and Mrs. Clifford Riddel, both of Bridgewater, Va.



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Contraindications: Known hypersensitivity to drug; children under 6 months of age; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in treatment of psychotic patients, and should not be employed in lieu of appropriate treatment. As with most CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may also be associated with temporary increase in frequency and/or severity of seizures. Advise patients against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance. Keep addiction-prone individuals (such as drug addicts or alcoholics) under careful surveillance because of their predisposition to habituation and dependence. Use of any drug in pregnancy, lactation or in women of childbearing age requires that potential benefit be weighed against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium, such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants. Employ usual precautions in the severely depressed or in those with latent depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

Adverse Reactions: Side effects most commonly reported: drowsiness, fatigue and ataxia. Infrequently encountered: confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo and blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, use of the drug should be discontinued. Because of isolated reports of neutropenia and jaundice, periodic blood counts and liver function tests are advisable during long-term therapy. Minor changes in EEG patterns (low-voltage fast activity) observed during and after therapy and are of no known significance.

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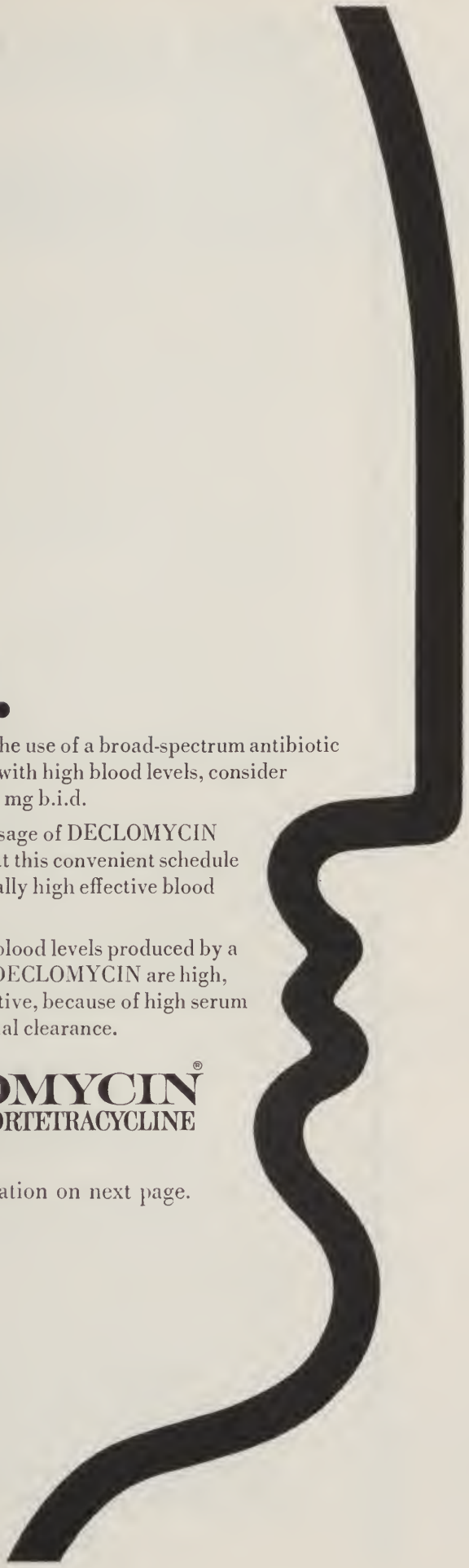
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Precautions—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

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ARTHRITIS FOUNDATION
Symposium—Chemotherapy in the Rheumatic Diseases: Astor Gallery, Waldorf-Astoria Hotel, NYC, 2 P.M. to 5:30 P.M. Contact: Charles Bennett, The Arthritis Foundation, 1212 Avenue of the Americas, New York, N. Y. 10036.

MAY 20-24, 1968
AMERICAN COLLEGE OF PHYSICIANS
Postgraduate Course—The Prevention and Early Detection of Disease in Clinical Practice: University of Pennsylvania School of Medicine, Philadelphia, Pa. Co-Directors: Norbert J. Roberts, MD, FACP, Thomas W. Clark, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa., 19104.

MAY 24, 1968
GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE/THE FOOD AND DRUG ADMINISTRATION
Symposium on Diabetes: 9 A.M., Gorman Auditorium, Medical Center campus, 3800 Reservoir Rd., Washington, D. C. Directors: Estelle R. Ramey, MD, professor of physiology and biophysics, Georgetown University School of Medicine, and Lillian Recant, MD, professor of medicine. Contact: Hal V. Kelly, Georgetown University News Service, Washington, D. C. 20007.

MAY 25-26, 1968
MARYLAND ACADEMY OF GENERAL PRACTICE
Annual Scientific Assembly/Annual Meeting: Statler Hilton Inn, Annapolis, Md. Contact: G. Overton Himmelwright, MD, Secretary, Maryland Academy of General Practice, 133 Virginia Ave., Cumberland, Md. 21502. (See page 32 for program details.)

MAY 27-30, 1968
HAHNEMANN MEDICAL COLLEGE AND HOSPITAL
Postgraduate Course—Auscultation of the Heart: Sheraton Hotel, Philadelphia, Pa. Directors: William Likoff, MD, Bernard L. Segal, MD. Contact: Sage Rosen, Assistant Director, Postgraduate Education, Hahnemann Medical College and Hospital, Department of Medicine, 230 N. Broad St., Philadelphia, Pa. 19102.

JUNE 7-8, 1968
THE JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE
Conference—Intrauterine Development and Fetal Management: Contact: A. E. Seeds, MD, Department of Gynecology and Obstetrics, The Johns Hopkins Hospital, Baltimore, Md. 21205.

JUNE 15, 1968
AMA/ASSOCIATION OF LIFE INSURANCE MEDICAL DIRECTORS OF AMERICA
Congress on Medicine and Insurance: San Francisco, Calif. Contact: Institute of Life Insurance, 277 Park Ave., New York, N. Y. 10017.

JUNE 19-22, 1968
AMERICAN COLLEGE OF PHYSICIANS
Postgraduate Course—Infectious Diseases: Mechanisms and Manifestations: University of Maryland School of Medicine, 29 S. Greene St., Balto., Md. Co-Directors: Theodore E. Wodward, MD, FACP, Richard B. Hornick, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

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Use of broad-spectrum antibiotics can cause fungal overgrowth in the alimentary tract... and give rise to symptoms so troublesome that therapy must be prematurely stopped. Tetrex-F (tetracycline phosphate complex-nystatin) helps you circumvent this problem.

The nystatin can prevent overgrowth of monilia; the phosphate complex delivers tetracycline to the blood rapidly. Side effects are infrequent.

High-Risk Patients

Tetrex-F (tetracycline phosphate complex-nystatin) is especially useful in patients most susceptible to fungal overgrowth during tetracycline therapy: (1) the elderly or debilitated, (2) young children, (3) the diabetic, (4) those on long-term tetracycline therapy, (5) those on steroid therapy, (6) those who have had moniliasis before, and (7) pregnant patients with a history of monilial vaginitis.

When you start with economical Tetrex-F (tetracycline phosphate complex-nystatin), you can complete the full course of broad-spectrum therapy with less chance of losing control elsewhere. A good start for a healthy finish.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

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executive secretary's newsletter

May, 1968

SEMIANNUAL MEETING RESOLUTIONS

Resolutions for consideration at the Faculty's Semiannual session on Friday, September 6, 1968, in Ocean City, Md., must be received in the Faculty office BEFORE FRIDAY, JULY 12, 1968.

No date has been set for the meeting of the Reference Committee, but all members will be notified of the date and resolutions to be considered. Such notices will be mailed as promptly as possible after July 12.

NEWS NOTES

New Diplomates of the American Board of Surgery include Manuel Sanchez, M.D., of Baltimore; and Wallace H.Sadowsky, M.D., of Havre de Grace.

Art H. Panayis, M.D., has opened his office for the practice of Obstetrics and Gynecology in Ellicott City.

Leo H. Bartemeier, M.D., Baltimore, is representing the American Medical Association at the World Federation of Mental Health meeting in London, England, August 12-17.

New Fellows of the American Society of Anesthesiologists are: Helmut F. Cascorbi, M.D., of Baltimore; Joseph David Lee, M.D., of Silver Spring; and Sergei L. Snegireff, M.D., of Bethesda.

NEW OFFICERS

Newly elected officers of the Maryland Ophthalmological Society include: Irvin P. Pollack, M.D., President; David M. Paton, M.D., Vice-president; Robert Sandler, M.D., Secretary-Treasurer.

BANK CHARGE CARDS

Because several queries have been received in the Faculty Office with respect to use of Bank Charge Cards by patients for services rendered to them, members are reminded that the use of such cards is considered unethical.

Full details on this and similar ethical rulings may be obtained from the Faculty office.

MEDICAL PRACTICE ACT REVISIONS

The report of the Ad Hoc Committee to Consider Changes in the Medical Practice Act was presented to the Faculty's House of Delegates meeting in April.

No action was needed or taken at that time, pending receipt of comments from individual members, Delegates, Components and others. Copies can be obtained through the Faculty office.

MEDICAL

PRACTICE ACT

REVISIONS

(continued)

Basically, there are few substantive changes and these involved only the following points;

1. Deletion of specific subjects spelled out in the law in which examinations should be given. This will be established by regulation of the Board, making it more flexible so that changes can be made as medical school curricula change.

2. Provides for the issuance of a Temporary Permit to practice medicine for the purpose of post-graduate teaching.

3. Deletes the fee for examination, secrecy of the examinee's names, school of graduation, etc., the form of license, all of which will be established by the Board.

4. Deletion of the requirement that a license be filed with the clerk of the circuit court in which the physician resides.

5. Deletion of the statement as to what constitutes advertising. The power to determine this in regulation form has been given to the Board.

6. No changes were made in various sections dealing with:

(a) Commission on Medical Discipline, enacted at the 1968 General Assembly.

(b) Transplantation of organs section, enacted at the 1968 General Assembly.

(c) Abortion sections, enacted at the 1968 General Assembly.

(d) Parental consent section, enacted at the 1967 General Assembly.

Comments from individual members, Delegates, Officers and Component Societies are solicited prior to the Semiannual Faculty meeting, when, if approved, it will be submitted to the Legislative Council for its consideration and, hopefully, passage at the 1969 Legislative Session.

Newly elected to membership on the Blue Shield Board of Trustees is George D. Edwards, M.D., Towson.

BLUE SHIELD ELECTIONS

Officers of this group are: J. Sheldon Eastland, M.D., Baltimore, President; Charles F. O'Donnell, M.D., Towson, Vice-President; F. Ford Loker, M.D., Baltimore, Secretary; and Mr. F. Edward Rugemer, Treasurer.

John Sargeant
Executive Secretary

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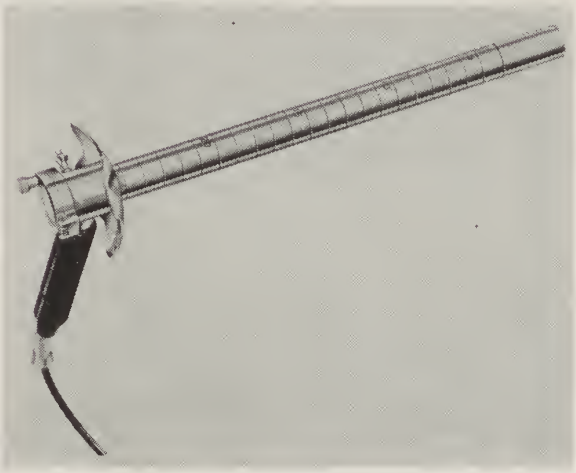
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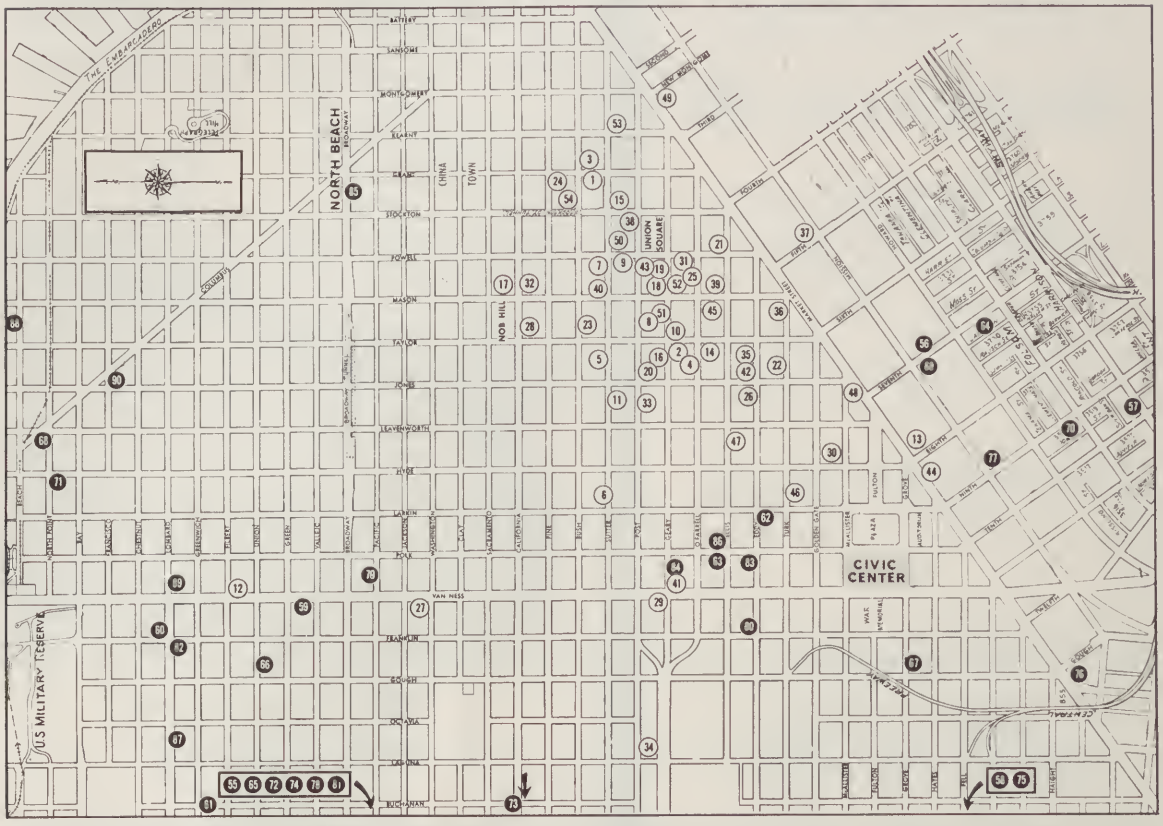
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CHANGES

ALL OTHER CHANGES TO BE MADE DIRECT WITH HOTEL AT ALL TIMES.

THIS FORM MAY ALSO BE USED FOR MEETINGS (JUNE 10-15), PRIOR TO AMA CONVENTION, BUT ROOMS MUST BE RELEASED ON DATE INDICATED.

IF YOU ARE AN INDUSTRIAL EXHIBITOR, BE SURE TO GIVE NAME OF FIRM AND INDIVIDUALS TO OCCUPY ROOM OR ROOMS RESERVED. PLEASE MAKE ALL CHANGES AND CANCELLATIONS THROUGH THE HOUSING BUREAU. HOTEL RESERVATIONS WILL BE HELD ONLY UNTIL 6:00 P.M. UNLESS OTHERWISE SPECIFIED.

DOWNTOWN SAN FRANCISCO HOTELS

MAP NO.	HOTELS	SINGLES	DOUBLES	TWINS	SUITES
1.	BALDWIN HOTEL	10.00-12.00	10.00-12.00	12.00-15.00	—
2.	BELLEVUE HOTEL	12.00-13.00	15.00-16.00	18.00-19.00	35.00-45.00
3.	BEVERLY PLAZA HOTEL	12.00	16.00	18.00	28.00
4.	CALIFORNIAN HOTEL	14.00	16.50	17.50	27.00
5.	CANTERBURY HOTEL	12.00-14.00	16.00	18.00-20.00	35.00-55.00
6.	CARLTON HOTEL	6.50-7.50	7.50-8.50	9.50-10.50	—
7.	CARTWRIGHT HOTEL	12.00	12.00	14.00	
8.	CECIL HOTEL	14.00	17.00	18.00	25.00
9.	CHANCELLOR HOTEL	11.00	14.00	16.00	—
10.	CLIFT HOTEL	16.00-32.00	21.00-35.00	21.00-35.00	—
11.	COMMODORE HOTEL	18.00	18.00-22.00	22.00-26.00	—
12.	CONTINENTAL LODGE	16.75-18.75	20.75-24.75	22.75-26.75	42.75
13.	DEL WEBB'S TOWNEHOUSE	16.00-25.00	18.00-25.00	20.00-28.00	42.00-75.00
14.	DON HOTEL	10.50	11.50	12.50	—
15.	DRAKE-WILTSHIRE HOTEL	12.50	15.00	20.00	50.00
16.	EL CORTEZ HOTEL*	10.00-14.00	12.00-14.00	14.00-16.00	28.00-30.00
17.	FAIRMONT HOTEL	(HEADQUARTERS HOTEL—NO ROOMS AVAILABLE)			
18.	FIELDING HOTEL	13.00	16.00	18.00	—
19.	FRANCISCAN HOTEL	9.00-10.00	12.00-13.00	13.00-15.00	—
20.	GAYLORD HOTEL	12.00-14.00	12.00-14.00	13.00-16.00	—
21.	GOLDEN STATE HOTEL*	9.00-10.00	10.00-12.00	14.00	—
22.	GOVERNOR HOTEL*	10.00-12.00	15.00	15.00-16.00	—
23.	GRANT HOTEL	8.50	11.00	12.50	—
24.	GRANT AVENUE HOTEL	9.00-11.00	11.00-13.00	12.00-15.00	—
25.	HANDLERY INN	20.00-24.00	24.00-30.00	24.00-30.00	—
26.	HERALD HOTEL	6.50	8.50	12.00	—
27.	HOLIDAY LODGE HOTEL	24.00	24.00	24.00	35.00
28.	HUNTINGTON HOTEL	(HEADQUARTERS HOTEL—NO ROOMS AVAILABLE)			
29.	JACK TAR HOTEL	17.00-31.00	20.00-34.00	22.00-34.00	48.00-100.00
30.	LAFAYETTE HOTEL	9.00	10.00	12.00	—
31.	MANX HOTEL	15.00-18.00	18.00-20.00	19.00-23.00	—
32.	MARK HOPKINS HOTEL	(HEADQUARTERS HOTEL—NO ROOMS AVAILABLE)			
33.	MAURICE HOTEL	14.00	14.00-16.00	15.00-17.00	25.00-30.00
34.	MIYAKO HOTEL	18.00-28.00	—	23.00-32.00	—
35.	OLYMPIC HOTEL	13.00-15.00	15.00-18.00	16.00-18.00	32.00-36.00
36.	OXFORD HOTEL*	—	13.00-14.00	14.00-17.00	40.00
37.	PICKWICK HOTEL	11.75	14.75	15.75	45.00
38.	PLAZA HOTEL	13.50-17.00	—	13.50-17.00	—
39.	RAMONA HOTEL	10.00	11.50	13.50	30.00
40.	REGENT HOTEL	8.00-9.00	10.00-11.00	11.00-12.00	—
41.	RICHELIEU HOTEL*	12.00-14.00	14.00-18.00	14.00-18.00	28.00-40.00
42.	ROOSEVELT HOTEL*	8.00-10.00	9.00-11.00	14.00	—
43.	ST. FRANCIS HOTEL (WOMAN'S AUXILIARY HDQRS.)	17.00-32.00	20.00-34.00	24.00-36.00	45.00-125.00
44.	SAN FRANCISCAN (formerly Whitcomb)	12.00-14.00	16.00-18.00	16.00-18.00	45.00-65.00
45.	SAN FRANCISCO HILTON	19.00-23.00	24.00-28.00	25.00-30.00	55.00-130.00
46.	SENATE HOTEL*	7.00-8.00	9.00-10.00	12.00-16.00	—
47.	SENATOR HOTEL	7.50-8.50	8.50- 9.50	9.50-10.50	—
48.	SHAW HOTEL*	6.50-9.50	8.50-10.50	9.50-20.00	20.00
49.	SHERATON PALACE HOTEL	16.50-20.00	20.50-24.50	20.50-24.00	37.50-100.00
50.	SIR FRANCIS DRAKE HOTEL	17.00-22.00	21.00-25.00	23.00-26.00	70.00
51.	SOMERTON HOTEL	10.00	14.00	16.00	—
52.	STEWART HOTEL	12.00-16.00	15.00-20.00	16.00-20.00	35.00-75.00
53.	SUTTER HOTEL	11.00-12.00	14.00-16.00	15.00-17.00	—
54.	VICTORIA HOTEL*	10.00	13.00	15.00	36.00

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55.	ALFA INN MOTEL	16.00-18.00	18.00-20.00	22.00-24.00	25.00-27.00
56.	AMERICANA MOTOR LODGE MOTEL*	18.50	18.50	22.50-24.50	33.50-36.50
57.	BAYBRIDGE DOWNTOWN MOTEL*	8.00	11.00	13.00-17.00	30.00-47.00
58.	BECK'S MOTOR LODGE	14.00	15.00	18.00-20.00	—
59.	BROADWAY MANOR MOTEL	16.00-20.00	18.00-21.00	24.00-28.50	—
60.	CABLE MOTEL*	18.50-26.50	18.50-26.50	20.50-26.50	36.50-45.50
61.	CAPRI MOTEL	12.00	14.00	16.00-18.00	25.00-30.00
62.	CARAVAN LODGE MOTEL	20.00-24.00	20.00-24.00	22.00-28.00	30.00-36.00
63.	CIVIC MANOR MOTEL*	14.50	14.50	16.50	—
64.	CORONET MOTEL	13.00	14.00	15.00	—
65.	DE VILLE MOTEL*	18.50	20.50	22.50	—
66.	DOYLE MOTEL*	11.50-21.50	13.50-21.50	14.50-17.50	—
67.	EXECUTIVE MOTEL*	10.00-12.00	14.00-16.00	16.00	24.00-28.00
68.	FISHERMAN'S WHARF TRAVELODGE*	20.00	20.00	22.00-24.00	—
69.	FLAMINGO CITY CENTER MOTEL*	16.50	16.50	19.50-22.50	—
70.	FRANCISCO CIVIC CENTER MOTEL*	16.50	16.50	20.50-22.50	—
71.	HYDE PARK SUITES	—	—	—	19.00-24.00
72.	LANAI MOTEL	20.00-24.00	—	20.00-24.00	28.00-45.00
73.	LAUREL MOTOR INN	15.00-18.00	18.00-25.00	24.00-30.00	35.00
74.	LOMBARD PLAZA MOTEL*	18.00-20.00	—	18.00-20.00	—
75.	MANOR MOTEL*	15.00	15.00	19.00-22.00	—
76.	MARKET STREET TRAVELODGE MOTEL	14.00	14.00	16.00	—
77.	MART MOTEL*	12.50	12.50	14.50-16.50	20.00-22.50
78.	MURRAY'S MOTEL*	15.50	15.50	17.50-19.50	—
79.	NOB HILL MOTEL	14.00-18.00	16.00-20.00	18.00-22.00	30.00-32.00
80.	OASIS MOTEL	12.00-14.00	14.00-16.00	16.00-18.00	30.00-35.00
81.	PRESIDIO TRAVELODGE	14.00	16.00	18.00	—
82.	RANCHO LOMBARD MOTEL*	18.50	18.50	18.50-24.50	36.50
83.	RED COACH MOTOR INN	16.50	16.50-21.50	19.50-23.50	28.50-37.50
84.	RICHELIEU MOTEL*	20.00	20.00	20.00	—
85.	ROYAL PACIFIC MOTEL*	18.50	18.50	22.50-24.50	—
86.	SAN FRANCISCO DOWNTOWN TRAVELODGE	14.00	14.00	18.00	—
87.	STAR MOTEL	16.00	16.00-18.00	—	—
88.	TRAVELODGE AT THE WHARF	16.00-20.00	16.00-20.00	20.00-22.00	—
89.	VAN NESS MOTEL	—	12.00-14.00	14.00-17.00	20.00-24.00
90.	VILLA ROMA MOTOR HOTEL*	25.00	—	25.00	—

EASTBAY

	SINGLES	DOUBLES	TWINS	SUITES
BEL AIRE MOTEL 3201 Steiner St., San Francisco	14.00	14.00	16.00	—
BERKELEY HOUSE HOTEL 920 University Avenue, Berkeley	12.00	16.00	16.00	—
BERKELEY PLAZA MOTEL 1175 University Avenue, Berkeley	8.00	10.00	11.00	20.00
BOATEL & MOTOR LODGE MOTEL* 21 Jack London Square, Oakland	15.00-16.00	—	19.00-20.00	—
EDGEWATER INN GARDEN HOTEL 455 Hegenberger Road, Oakland	14.00	18.00	18.00	—
HILLCREST MOTOR HOTEL 2400 MacArthur Blvd., Oakland	7.50-9.00	9.00-10.50	11.00-13.00	21.00
HOLIDAY INN OF OAKLAND 500 Hegenberger Road, Oakland	11.00-12.50	15.00	17.00	—
JACK LONDON INN Jack London Square, 444 1st Street, Oakland	13.00-16.00	16.00-20.00	16.00-20.00	27.00-30.00
LAKE MERRITT HOTEL 1800 Madison, Oakland	12.50	14.50	14.50	18.50-30.00
LEAMINGTON HOTEL 19th & Franklin Streets, Oakland	12.00	16.00	20.00	—
LINOAKS MOTEL 2310 Lincoln, Alameda	10.00-14.00	12.00-16.00	16.00	—
MARINA LODGE 975 University Avenue, Berkeley	10.00	10.00-12.00	14.00	—

PENINSULA

PALO ALTO CABANA HOTEL 4290 El Camino Real, Palo Alto	15.00	20.00	35.00	—
EL RANCHO MOTEL* 1100 El Camino Real, Millbrae	16.00	16.00	16.00-18.50	26.00-30.00
HILLSDALE INN 477 E. Hillsdale Blvd., San Mateo	18.00	18.00	20.00	24.00-34.00
HILTON INN International Airport, South San Francisco	17.00	21.00	21.00	—
HYATT HOUSE 1333 Bayshore, Burlingame	—	22.00	24.00	60.00-82.00
IMPERIAL 400 MOTEL 222 S. Airport Blvd., South San Francisco	14.00-16.00	—	14.00-16.00	—
INTERNATIONAL INN MOTEL 326 S. Airport Blvd., South San Francisco	18.00	22.00-24.50	22.00-24.50	—
KNIGHTS REST MOTOR LODGE 3rd & San Bruno Avenues, San Bruno	10.00-12.00	12.00-14.00	14.00-16.00	—
RAMADA INN 1250 Bayshore Blvd., Burlingame	14.50	—	19.50	—
THUNDERBOLT 101 Bayshore Blvd., Millbrae	16.00-18.00	21.00-23.00	22.00-24.00	45.00-50.00
VILLA 4000 So. El Camino Real, San Mateo	15.00-18.00	18.00-21.00	17.00-22.00	37.00-70.00

MARIN COUNTY

HI-HO MOTEL 707 A Redwood Hwy., Mill Valley	12.00-14.00	14.00-16.00	16.50-18.50	—
MADERA VILLAGE INN 45 Tamal Vista, Corte Madera	13.00	15.00	17.00	22.00
TIBURON LODGE MOTEL 1651 Tuburon Blvd., Tiburon	14.00-17.00	16.00-19.00	18.00-21.00	—

*Family Accommodations.
Family accommodations or other specific requests should be directed to the Housing Bureau.

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AMA BYLAWS

Chapter VI. Meetings-Section 2. Registration (A) Members. A Member's Section registration shall correspond with his specialty or General Practice status as designated by him for classification in the American Medical Association Directory. To be accepted for Section registration purposes, a member of a Section who desires to change his registration from one Section to another because of a change in his specialty, shall be required to inform the Headquarters of The American Medical Association by written notice of this intention at least sixty days in advance of the Annual Convention.

Chapter VII. Sections-Section 7. Participation in Business Only active members registered in accordance with Chapter VI, Section 2 (A) shall have the right to participate in the business deliberation of a section.

PLEASE NOTE

An Active physician member may not change his Section registration for voting purposes from one Section to another Section, unless written notice of a change in his specialty has been given the AMA Headquarters at least 60 days (by April 16, 1968) in advance of the opening day of the Annual Convention.

Upon completion of an Active Member's Registration at the AMA Registration Desk, members will not be permitted to switch from one Section registration to another Section registration during the entire period that the AMA Annual Convention is in session.

However, all members are encouraged to attend any and all of the Scientific Section programs. Such attendance has no direct connection with the Section in which an Active Member may wish to be qualified to vote.

American Medical Association's 117th Annual Convention
San Francisco, California • June 16-20, 1968

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Reception and Dinner in honor of the Scientific Award Winners, Wednesday, June 19, 1968; Reception, 6:30 p.m. and Dinner, 7:30 p.m.

Dinner Tickets are $10.00 each, payable in advance.

My remittance of $_____ is enclosed.

Reservations are limited to approximately 500 people.

Advance Reservations may be made until June 3, 1968. After this date, tickets may be purchased in San Francisco.

In accordance with the AMA Bylaws, I hold active membership in the AMA and I wish to vote in the Scientific Section I have checked:

- ☐ Allergy
- ☐ Anesthesiology
- ☐ Colon and Rectal Surgery
- ☐ Dermatology
- ☐ Diseases of the Chest
- ☐ Experimental Medicine and Therapeutics
- ☐ Gastroenterology
- ☐ General Practice
- ☐ General Surgery
- ☐ Internal Medicine
- ☐ Laryngology, Otology and Rhinology
- ☐ Military Medicine
- ☐ Nervous and Mental Diseases
- ☐ Obstetrics and Gynecology
- ☐ Ophthalmology
- ☐ Orthopedic Surgery
- ☐ Pathology and Physiology
- ☐ Pediatrics
- ☐ Physical Medicine
- ☐ Preventive Medicine
- ☐ Radiology
- ☐ Urology

(Only Active Members Will Be Permitted To Vote)

The American Medical Association stated that the regional medical programs had showed good progress in the early stages but urged that Congress order an early evaluation by a non-government agency.

The AMA position was outlined by Bland W. Cannon, MD, of Memphis, Tenn., a member of the Association Council on Medical Education, in testimony before the House Subcommittee on Public Health and Welfare. The subcommittee was considering Administration legislation to extend the regional medical program law for five years.

Subcommittee members reacted favorably to an AMA recommendation that the extension be for only three years. Some of the congressmen also indicated opposition to a recommendation by Michael DeBakey, MD, of Houston, Texas, that appropriations for the regional medical programs be increased sharply.

"We view with favor the early progress of RMP, its ability to build on existing patterns of medical care (sometimes adding new features or changing old ones as local demands and resources make possible) and the local flexibility which allows the program to make a real contribution to the health care of our nation," Dr. Cannon said. "At the same time, we recognize that the concept of the Regional Medical Program is still in its very early stage of existence and that it is difficult to fully appraise the program. We do not know, for example, how much this program adds to the stress on an already overtaxed supply of available medical manpower.

"There is some concern that the proliferation of federal health programs substantially contributes to the rise in health care costs. For this reason, we are pleased that H.R. 15758 provides for an evaluation of the program. We would suggest, however, that the evaluation begin July 1, 1968, rather than July 1, 1969, since 'evaluation' should be an integral part of the planning. We also suggest that the subcommittee consider further amending Section 102 to provide that the evaluation shall be made by a non-government agency. . . .

"We recommend that the subcommittee delete the open-end authorization for funds for the four fiscal years ending after June 30, 1969. In view of the fact that we are still dealing with a relatively untried program, we believe it would be wise to limit the authorization to such sums as this subcommittee may determine to be reasonable, rather than to provide 'such sums as may be necessary for the next four fiscal years.' "

Henry Brill, MD, of Brentwood, N.Y., chairman of the AMA's Committee on Alcoholism and Drug Dependence, said that the AMA supported the part of the legislation authorizing federal grant for construction of facilities for a new program for alcoholic and narcotic addict rehabilitation.

"However," he said, "we have long felt that funds for staffing and operation are properly the responsibility of the community, once the major burden of construction has been met with federal assistance."

Reorganization of HEW

Wilbur J. Cohen, a key proponent of medicare, was named by President Johnson to succeed John W. Gardner as Secretary of Health, Education and Welfare.

Mr. Cohen, now 54, started with the federal government in the early thirties and helped draft the social security program. Recognized by Congress as an expert on social security, he was the leading architect of medicare and played a prominent role in getting Congressional approval of the program.

He had been Undersecretary of HEW since June, 1965. For the previous four years, he had been Assistant Secretary of HEW.

At a news conference following his appointment to the top HEW post, Cohen foresaw health care accounting for as much as 50% of total welfare costs. He urged that voluntary private health insurance be improved. But he said he did not believe private programs could be improved sufficiently to eliminate the need for government help in dealing with the health care needs of low income groups and the disabled.

"Medicare and medicaid have had some impact on higher medical costs," Cohen said. "But I think doctors' costs are going to taper off. Hospital costs are going to continue to rise but there is a problem of antiquated and inefficient methods. This can be changed."

Soon after Gardner's resignation becomes effective, Cohen announced major steps in the reorganization of HEW's health activities. Unified

direction of HEW's major health agencies was assigned to Philip R. Lee, MD, Assistant Secretary for Health and Scientific Affairs. William H. Stewart, MD, Surgeon General of the Public Health Service, was named principal deputy to Dr. Lee.

Dr. Lee was given direct authority over the Public Health Service and the Food and Drug Administration. Dr. Stewart and Food and Drug Commissioner James L. Goddard, MD, will report directly to the Assistant Secretary, while continuing their present administrative duties.

Dr. Lee's responsibility also was expanded to include overall health policy direction and coordination of other health programs, including medicare, medicaid and the health activities of the children's bureau.

In his 1968 message to Congress, President Johnson had directed the HEW secretary to submit "a modern plan of organization to achieve the most efficient and economical operation of the health programs of the federal government."

"In the past four years," Cohen said, "31 major new laws have been enacted that increase the Department's authority, responsibility and appropriations in the field of health.

"The total federal investment in health has grown from approximately $3 billion in 1960 to nearly $14 billion in 1968, and $16 billion proposed in 1969. Because of new programs, like medicare and medicaid, the HEW health investment alone has more than tripled in the past three years, from $2.6 billion in 1966 to $9.6 billion this fiscal year, and $10.9 billion proposed for 1969."

In a reassignment of agency responsibilities, the National Institutes of Health was expanded to include the present NIH, the Bureau of Health Manpower and the National Library of Medicine. The Health Services and Mental Health Administration was set up with responsibility for all other functions previously assigned to the Public Health Service. These two new agencies, along with the present Food and Drug Administration now make up an expanded and more comprehensive Public Health Service.

James A. Shannon, MD, Director of the National Institutes of Health, was named Director of the newly constituted NIH. Dr. Robert Q. Marston, Director of the Division of Regional Medical Programs, was named Acting Administrator of the Health Services and Mental Health Administration. Dr. Goddard continues as Commissioner of Food and Drugs. The heads of these three agencies will report directly to Dr. Lee under the new organizational setup.



Justice Department Assumes Drug Control

On April 7, Presidential Reorganization Plan No. 1 became effective, creating in the Department of Justice, a new bureau of Narcotics and Dangerous Drugs.

The new bureau assumes the responsibility for the drug enforcement functions previously delegated to the Bureau of Narcotics and the Bureau of Drug Abuse Control. The reorganization plan was originally proposed by the President in his special message on crime to the Congress on February 7, at which time he said that the new bureau would ". . . bring to the American people the most efficient and effective federal enforcement machinery we can devise."

The Bureau of Narcotics and Dangerous Drugs also assumes the educational functions previously delegated to the Bureau of Narcotics and the Bureau of Drug Abuse Control.

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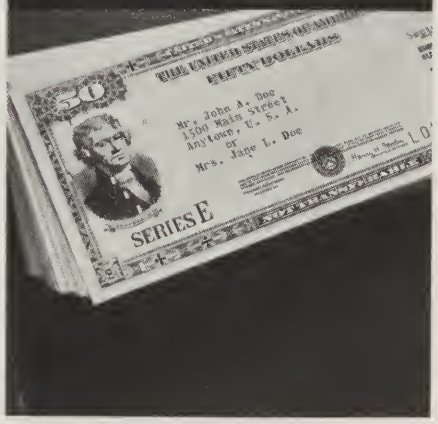
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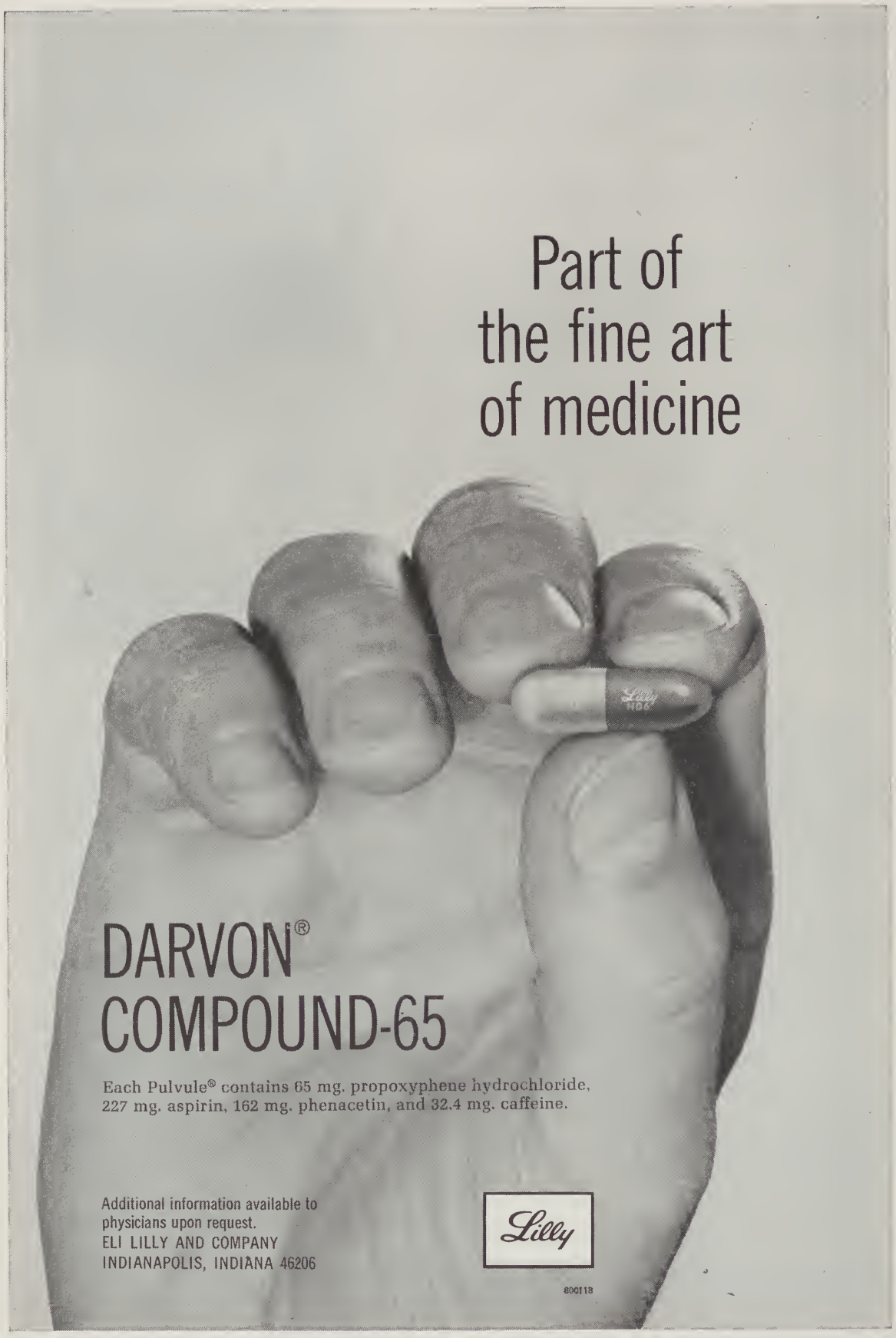


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Social Security—Benefits & Tax Climb

Congress has passed a compromise plan to add $3.6 billion per year to social security benefits for 24 million people. The benefits are somewhat less than asked for by the administration and approved by the Senate. So is the added tax burden.

Benefit increases—

effective in March, 1968 amount to 13% across the board. The minimum benefit for a retired worker will increase to $55 from $44. And a retired worker may earn $1,680 without forfeiting any of his benefits.

Taxes will be increased—

in January 1968 only for those earning between $6,600, the current maximum wage base, and $7,800, the new maximum wage base. The tax rate for next year will remain 4.4% each on employees and employers but the increase in the wage base raises their maximum tax to $343.20. Currently, maximum tax paid by each is $290.40.

The tax rate is set to go to 4.8% in 1969 so the maximum tax will rise to $374.40 for both 1969 and 1970. It will continue to increase every few years until it reaches $460.20 in 1987 (see chart). All taxes are matched by employers.

Self-employed persons—

will pay about 50% more than other workers amounting to a maximum tax in 1968 to a few cents short of $500.00. By 1973, self-employed persons would be taxed up to $596.70 for their Social Security.

Medicare patients—

now limited to 90 days of hospital care for each "spell of illness," will get an added "lifetime reserve" of 60 days of hospitalization of which they will pay $20.00 per day.

Medicaid—

which provides free medical care in whole or in part to families earning below a given income level established by each state, will now have a federal income standard applied which will affect the federal contributions made to each state. For example, New York provides Medicaid for a family of four with a net income of less than $6,000. The new rule would eventually limit federal participation to only those families earning less than $3,900. In California the income ceiling for a family of four would be cut from $3,900 to $3,100.

OLD AND NEW SOCIAL SECURITY TAX SCHEDULE

YEAR	Tax Rate		Maximum Tax for Employer & Employee		Maximum tax Per Job
	Old Law	New Law	Old Law	New Law	New Law
Now	4.4%	..	290.40	..	..
1968	4.4	4.4%	290.40	343.20	686.40
1969-70	4.9	4.8	323.40	374.40	748.80
1971-72	4.9	5.2	323.40	405.60	811.20
1973-75	5.4	5.65	356.40	440.70	881.40
1976-79	5.45	5.7	359.70	444.60	889.20
1980-86	5.55	5.8	366.30	452.40	904.80
1987-	5.65	5.9	372.90	460.20	920.40

Note: Self-employed persons pay about 50% more than employees

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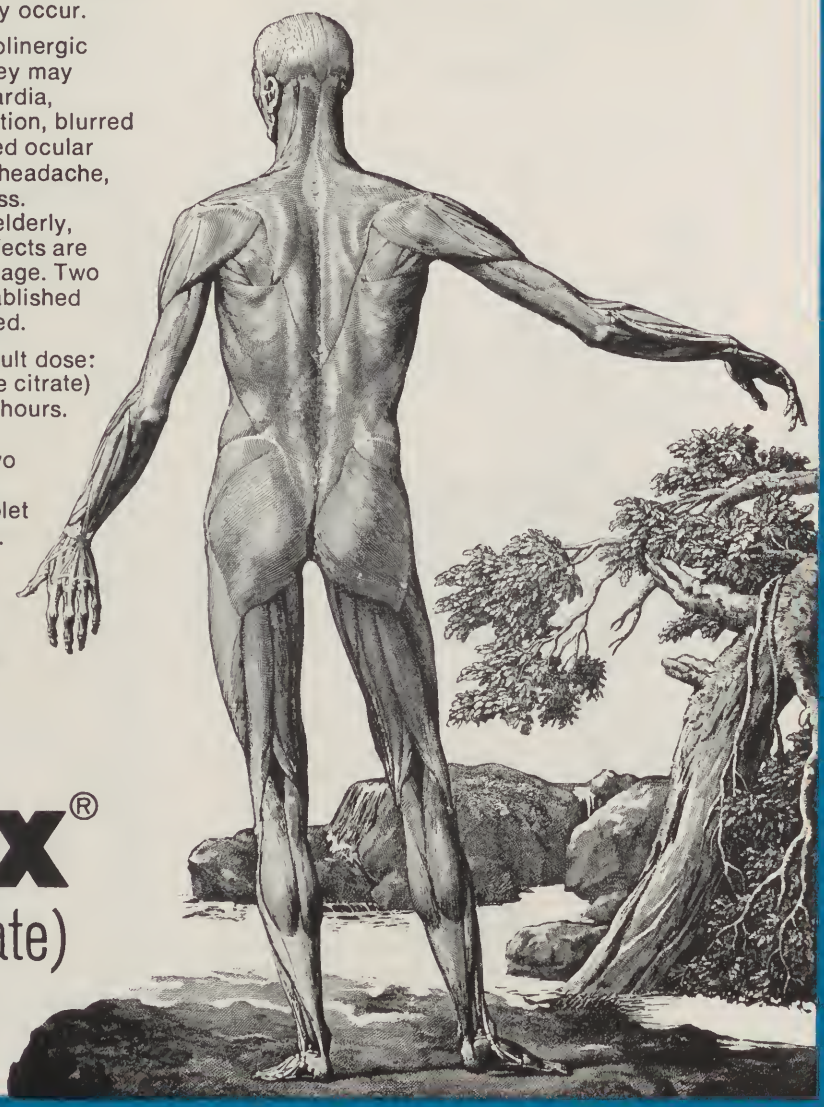
WARNING: Transient lightheadedness or dizziness following NORFLEX-INJECTABLE may occur.

SIDE EFFECTS: Due mainly to anticholinergic action and usually at high dosage. They may include dryness of the mouth, tachycardia, palpitation, urinary hesitancy or retention, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, and drowsiness. Infrequently, mental confusion in the elderly, urticaria or other dermatoses. Side effects are usually eliminated by reduction in dosage. Two cases of aplastic anemia, with no established causal relationship, have been reported.

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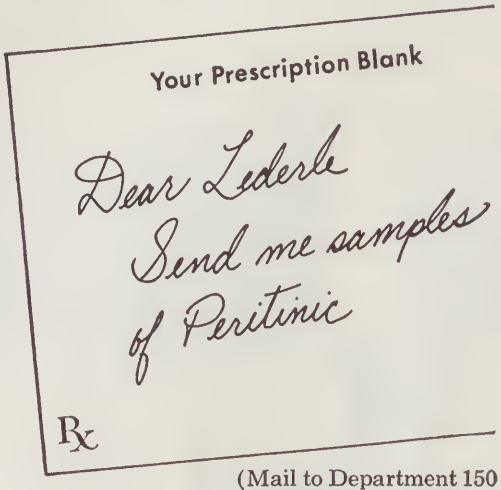
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AMA Warns of Potential Hazards in

The American Medical Association recently issued a word of warning concerning commercially promoted "clubs" for weight losers.

"Since excess weight may be a symptom of illness, it is vital for any person who wants to lose weight to have a physical examination by his physician before participating in any of these so-called club programs," the AMA said.

Several such clubs are now in operation. They are frequently operated locally by a businessman who obtained a franchise from a national headquarters organization.

"The regimen and rapport of group 'workouts' that are being commercially promoted throughout the country may give the overweight person some moral support for his effort at weight reduction and little else," the AMA said. "The group approach may be satisfactory for the person who wants to lose a few pounds and can afford the fee charged by a club.

"The group approach that does not include a complete, preliminary physical examination and

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medical supervision is definitely not satisfactory for the person who is significantly overweight, or who plans to lose 15% or more of his total weight. Significant weight reduction must be carried out under the supervision of a physician.

"There is in the overweight population a higher incidence of hypertension, cardiovascular and kidney diseases, disorders of the liver and gallbladder, and diabetes mellitus.

"Sudden loss of significant amounts of weight, or the requirement for an unusual amount of exercise, may be hazardous for the patient with any of these conditions.

"Adequate treatment of obesity (significant overweight) is often a more complex matter than diet and exercise, the usual club regimen. While simple over-eating and under-exercising may be a cause of obesity, significant overweight frequently has a genetic, metabolic or psychological component which requires medical diagnosis and treatment. Because there is no single cause of obesity, there is no single proper treatment to correct it."

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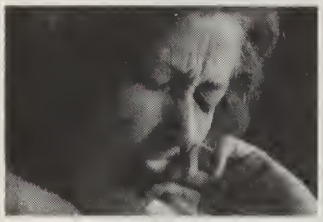
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*Paregoric (equivalent) ..... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified) .... (85 grains) 5.5 Gm.
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She needs counsel and reassurance, and perhaps a tranquilizer to attenuate excessive tension and help restore the capacity to cope. As an aid to successful management, consider the value of Valium® (diazepam). As psychic tension is eased by Valium therapy, secondary depressive symptoms too may subside. The patient feels more capable, therefore more hopeful; better able to handle situations of intense stress.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindications: Known hypersensitivity to drug; children under 6 months of age; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in treatment of psychotic patients, and should not be employed in lieu of appropriate treatment. As with most CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may also be associated with temporary increase in frequency and/or severity of seizures. Advise patients against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance. Keep addiction-prone individuals (such as drug addicts or alcoholics) under careful surveillance because of their predisposition to habituation and dependence. Use of any drug in pregnancy, lactation or in women of childbearing age requires that potential benefit be weighed against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects —particularly with known compounds which may potentiate action of Valium, such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants. Employ usual precautions in the severely depressed or in those with latent depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

Adverse Reactions: Side effects most commonly reported: drowsiness, fatigue and ataxia. Infrequently encountered: confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo and blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, use of the drug should be discontinued. Because of isolated reports of neutropenia and jaundice, periodic blood counts and liver function tests are advisable during long-term therapy. Minor changes in EEG patterns (low-voltage fast activity) observed during and after therapy and are of no known significance.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See **Precautions.**) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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First Meeting of National Association of Medical Examiners Held

The National Association of Medical Examiners held its first annual meeting on February 21, 1968 in Chicago, where it elected officers, a Board of Directors and an Executive Committee and adopted a set of By-Laws for the organization.

The Association elected as its President Milton Helpern, MD, Chief Medical Examiner of New York City and one of the founders of the organization. Joseph W. Spelman, MD, Medical Examiner of Philadelphia, was elected Vice President and Leslie Lukash, MD, Medical Examiner of Nassau County, East Meadow, New York, was elected Secretary-Treasurer. All three officers will serve one-year terms.

The following were elected to three-year terms on the Executive Committee: Lester Adelson, MD, Pathologist and Chief Deputy Coroner, County of Cuyahoga, Cleveland, Ohio; John I. Coe, MD, Medical Examiner of Hennepin County, Minneapolis, Minn.; Daniel J. Condon, MD, Medical Examiner, Maricopa County, Phoenix, Arizona; Ali Z. Hameli, MD, Chief Medical Examiner, State of Delaware, Wilmington, Delaware; R. C. Henry, MD, Chief Medical Investigator, State of Oregon, Portland, Oregon; Joseph A. Jachimczyk, MD, Chief Medical Examiner, Harris County, Houston, Texas; and Charles P. Larson, MD, Director of Laboratories, Tacoma General Hospital, Tacoma, Washington.

Those elected to two-year terms on the Executive Committee were: Edwin Albano, MD, Chief Medical Examiner, Essex County, Newark, New Jersey; Richard Ford, MD, Medical Examiner, Southern Division of Suffolk County, Boston, Mass.; Alvin V. Majoska, MD, Chief Medical Examiner, City and County of Honolulu, Honolulu, Hawaii; Geoffrey T. Mann, MD, Chief Medical Examiner, Commonwealth of Virginia, Richmond, Va.; Charles S. Petty, MD, Professor of Pathology, University of Indiana School of Medicine, Indianapolis, Ind.; Sidney B. Weinberg, MD, Chief Medical Examiner, Suffolk County, Happauge, New York; and William C. Wilentz, MD, Chief Medical Examiner, Middlesex County, Perth Amboy, New Jersey.

The Association elected the following to the Executive Committee for one-year terms: Victoria A. Bradess, MD, Chief Medical Examiner, Westchester County, Valhalla, New York; Theodore I. Curphey, MD, recently-retired Chief Medical Examiner-Coroner, Los Angeles County, Los Angeles, California; Robert M. Greendyke, MD, Medical Examiner, Monroe County, Rochester, New York; Robert Hausman, MD, Chief Medical Examiner, Bexar County, San Antonio, Texas; Martin Hilfinger, MD, Chief Medical Examiner, Onondaga County, Syracuse, New York; Michael Luongo, MD, Medical Examiner, Northern Division, Suffolk County, Boston, Mass.; and T. C. Terrell, MD, Chief Medical Examiner, Tarrant County, Fort Worth, Texas. In future years all Executive Committee members will be elected for three-year terms, thus providing for a staggered system of elections.

Russell S. Fisher, MD, Chief Medical Examiner, State of Maryland, Baltimore, Maryland, was elected Chairman of the Executive Committee, a position that will be filled in future years by the immediate past president.

The Board of Directors will consist next year of the three officers and Drs. Fisher, Hausman, Larson and Majoska. The last three were named to the Board by the Executive Committee. In future years the Board will consist of the three officers, the immediate past president and three members of the Executive Committee. All members of the Board of Directors will serve one-year terms.

The meeting adopted the following aims and purposes as part of the By-Laws:

> To improve and make more effective the official investigation of sudden, suspicious and violent deaths under the medical examiner system; to strengthen the administration and operation of the medical examiner system; to assist in and encourage the establishment of the medical examiner system in areas where such a system is not now in effect; to establish, maintain and promote proper standards

for a model medical examiner system; to disseminate accurate information regarding the medical examiner system and its contributions to the administration of justice and the protection of the health of the community; to advance the professional interests of the medical examiners, including those relating to the administrative and career aspects of their work; to conduct studies, sponsor publications and undertake other activities and projects designed to assist medical examiners in improving the quality of their work; and to establish and maintain a code of ethics.

The Association plans to conduct a membership drive to obtain as many qualified members as possible.

Membership in NAME is open to all medical examiners, pathologists and other licensed physicians who have responsibilities in connection with the official investigation of sudden, suspicious and violent deaths.

Interested physicians are invited to write to the National Association of Medical Examiners, 520 First Avenue, New York, N. Y. 10016.

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$20 Billion

Spent on Mental Illness in 1966 .

Despite steady improvement in treatment services, mental illness cost U. S. citizens more than $20 billion in 1966. Figures reported by Stanley F. Yolles, MD, Director of the National Institute of Mental Health, show that mental illness cost Americans an average of almost $48 each that year.

Commenting on the NIMH study, Wilbur J. Cohen, Secretary of the Department of Health, Education, and Welfare, which includes NIMH, said the costs would have been even higher had it not been for many improvements in mental health services across the country.

"One of the Department's major priorities is to increase knowledge and manpower and improve treatment services in mental health," Mr. Cohen said, "and our efforts are paying off as shown by the latest survey of the number of resident patients in State and County mental hospitals."

The Secretary added that last year saw the sharpest decrease in resident patients in such hospitals since the downward trend began 12 years ago. He cited a 26,000-patient decrease which amounts to 5.8% for the year.

"Latest statistics show that as of June 30, 1967, there were 426,009 resident patients in State and County mental hospitals; 133,000 less than 12 years ago," Mr. Cohen said.

"However, the tremendous waste of mental illness revealed by the 1966 NIMH study shows the need for continuing efforts at every level of government and by all citizens to help reduce further the cost of such illness," he added.

The NIMH study showed that the largest part of the $20 billion, $15.5 billion, was attributed to decreased productivity. This was defined to include loss of marketable output ($14.3 billion),

Despite Improvement in Treatment Services

loss of homemaking services ($970 million) and loss of unpaid work such as home maintenance and volunteer services ($240 million).

Treatment and prevention of mental illness cost almost $4 billion. This included more than $2.5 billion spent on inpatient care and slightly more than $1 billion spent on outpatient care. Federal, State, and local government spent $328 million on: development of mental health facilities ($121 million), training of mental health personnel ($94 million), and mental health research ($113 million).

The NIMH did not attempt to estimate the cost of excessive gambling, promiscuity, illegitimacy, alcoholism and drug addiction resulting from mental illness.

The NIMH found that $9 billion, or about half of the cost of mental illness, was borne by someone other than the patient or his immediate family. The general public paid all but $500 million of the $3.5 billion of the cost of treating the mentally ill in 1966. Three-fourths of this $3 billion was expended by local, State, and Federal government agencies. Private insurance carriers, private industry, and private philanthropy accounted for the remainder. The patients or their families bore $500 million of the cost, averaging nearly $200 per patient. NIMH calculated these costs based on 2.6 million persons treated for mental or emotional illness in 1966. One-fifth of these, or 500,000, were hospitalized on any given day during the year. Costs were conservatively estimated, so actual costs probably ran even higher.

Copies of the report are available from the Public Information Branch, National Institute of Mental Health, Chevy Chase, Maryland 20203.

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Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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Maryland Academy of General Practice
1968 Scientific Assembly and Annual Meeting

The Annual Meeting of the Maryland Academy of General Practice on May 25 and 26 is of particular importance to all those who believe in the concept of general or family practice. The officers of the Academy have made an exceptional effort to provide a program with broad appeal to the members. The symposium will deal with varied aspects of pediatric care—the very foundation of general practice.

In addition to an outstanding scientific program, a number of prominent persons in the educational and political field have been invited to the banquet. Only by a strong showing on the part of the membership by good attendance can one prove that *The Academy* is a viable and aggressive organization.

SATURDAY, MAY 25, 1968

9:00 A.M. Registration and Welcome by John Ball, MD, President, Maryland Academy of General Practice

PEDIATRIC SYMPOSIUM

Moderator — Ephraim Lisansky, MD, Director, Continuing Education Committee, University of Maryland School of Medicine

9:30 A.M. Care of Baby in Utero

10:00 A.M. Care of Newborn in Nursery
Murray Kappelman, MD, Head of Nursery Section, Sinai Hospital, Baltimore

10:30 A.M. Coffee Break

10:40 A.M. Care of Neonate and Infant
Robert Tolson, MD, Pediatric Consultant, Washington, D. C.

11:20 A.M. Preventive Pediatrics, A New Look
William Anderson, MD, President, American Academy of Pediatrics 1966-1967

11:50 A.M. Questions

12:20 P.M. Lunch

1:30 P.M. Diagnosis and Treatment of Tonsillitis, Otitis, Upper and Lower Respiratory Diseases
Donald Delany, MD, Pediatrician-in-Chief, The Johns Hopkins Hospital, Baltimore

2:10 P.M. Diarrhea and Vomiting
Robert Cooke, MD, Pediatrician-in-Chief, The Johns Hopkins Hospital, Baltimore

2:40 P.M. Cardiac Murmurs and Heart Disease in Children
Karl Weaver, MD, Associate Professor and Acting Head, Department of Pediatrics, University of Maryland School of Medicine

3:10 P.M. Questions

3:30 P.M. Annual Meeting

7:00 P.M. Cocktails (*Host: The Taylor Manor Hospital, Ellicott City, Maryland*)

7:30 P.M. Banquet
Guest Speaker: *Congressman Charles McC. Mathias*
Subject: "Current Attitudes, Social and Political, As They Relate To Medicine"

SUNDAY, MAY 26, 1968

10:00 A.M. Pediatric Dermatology
Harry Robinson, MD, Professor of Dermatology, University of Maryland School of Medicine

10:30 A.M. Pediatric Allergy
Richard L. London, MD, Head of Pediatric Allergy Section, University of Maryland School of Medicine

11:00 A.M. Emotional Problems of Children and Adolescents
Reginald Lourie, MD, Chief of Psychiatry, Children's Hospital, Washington, D. C.

11:45 A.M. A Program of Sex Education
Margaret Paxson, MD, Planned Parenthood Association of Maryland

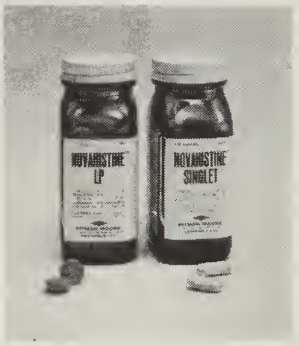
12:30 P.M. Questions

1:00 P.M. Adjournment

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See Brief Summary on final page of advertisement

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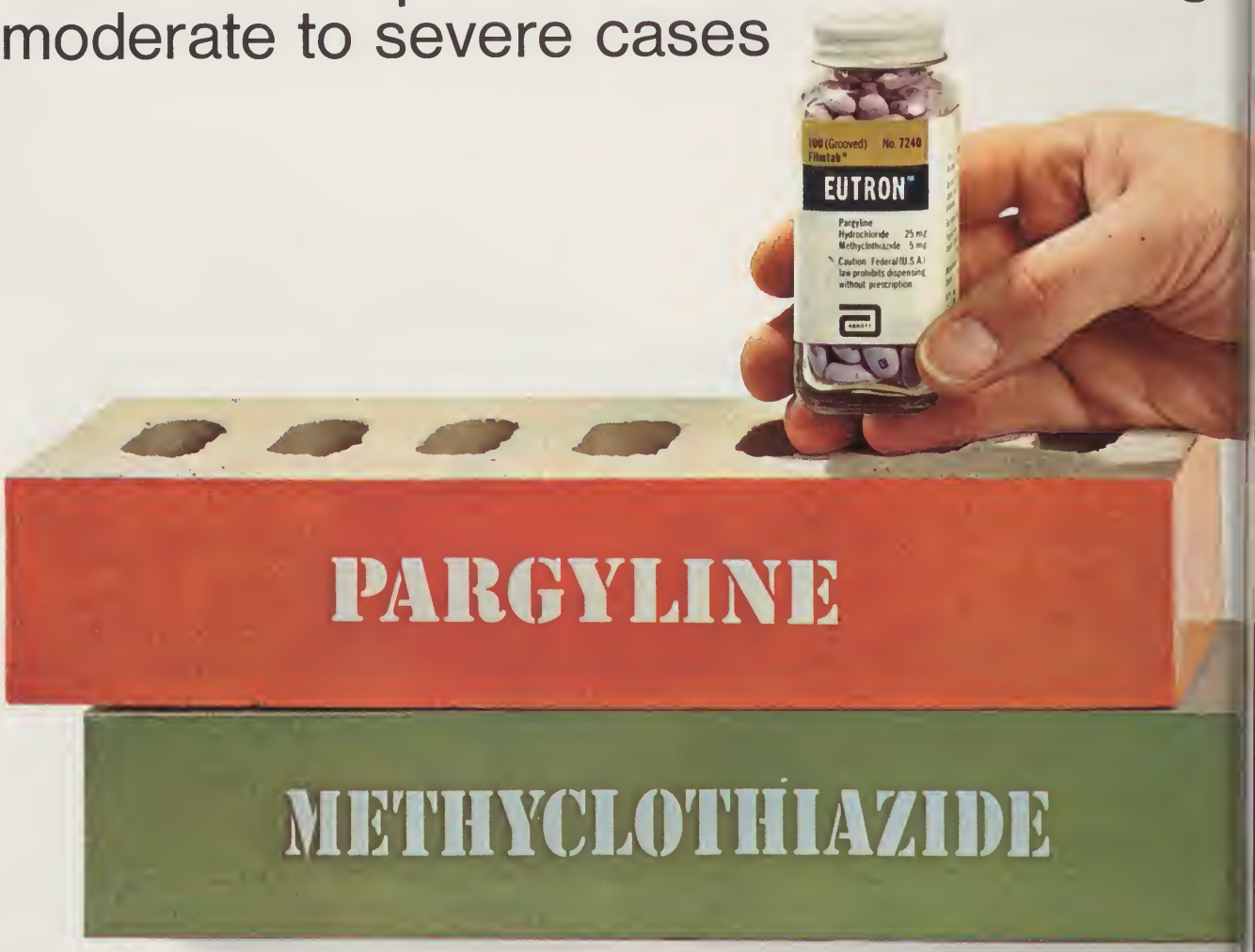
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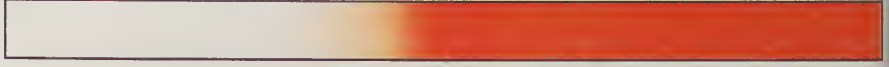
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MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

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Each tablet contains
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Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

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Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage; caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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Community Hospital Costs on the Rise

The cost to the nation's community hospitals to provide one patient with a day of care rose to an average of $58.06 in 1967, the American Hospital Association reported in the March 16 issue of *Hospitals,* Journal of the AHA.

The figure represents a 15.4% increase over the 1966 average expense of $50.31 per patient day, according to Hospital Indicators, a monthly report published in the Journal.

Increased utilization of hospital facilities played a part in the hospitals' total increased expenses, Hospital Indicators said. For example, total admissions to community hospitals were up nearly 1% in 1967 over 1966, and the average daily census increased 4.2% in the past year.

In addition, the length of patient stay increased from 7.7 days per admission in 1966 to 8.0 in 1967, and the number of outpatient visits jumped by 7% during the year. The occupancy rate was also up in 1967—from 77% to 78.1%.

The impact of Medicare upon hospital utilization by persons 65 and over is reflected in the 5.1% increase in the over-65 admissions reported in the last six months of 1967 over the same six months of 1966. The Medicare program began July 1, 1966.

The number of births in hospitals continued to decline in 1967. There were a reported 3.2 million births, a decrease of 1.5% from 1966.

Fulltime hospital employees increased again in 1967, according to Hospital Indicators. In 1946, there were 148 fulltime employees for every 100 patients, but in 1967 that ratio had risen to 264 employees per 100 patients.



Vacation trip....

Motion sickness?



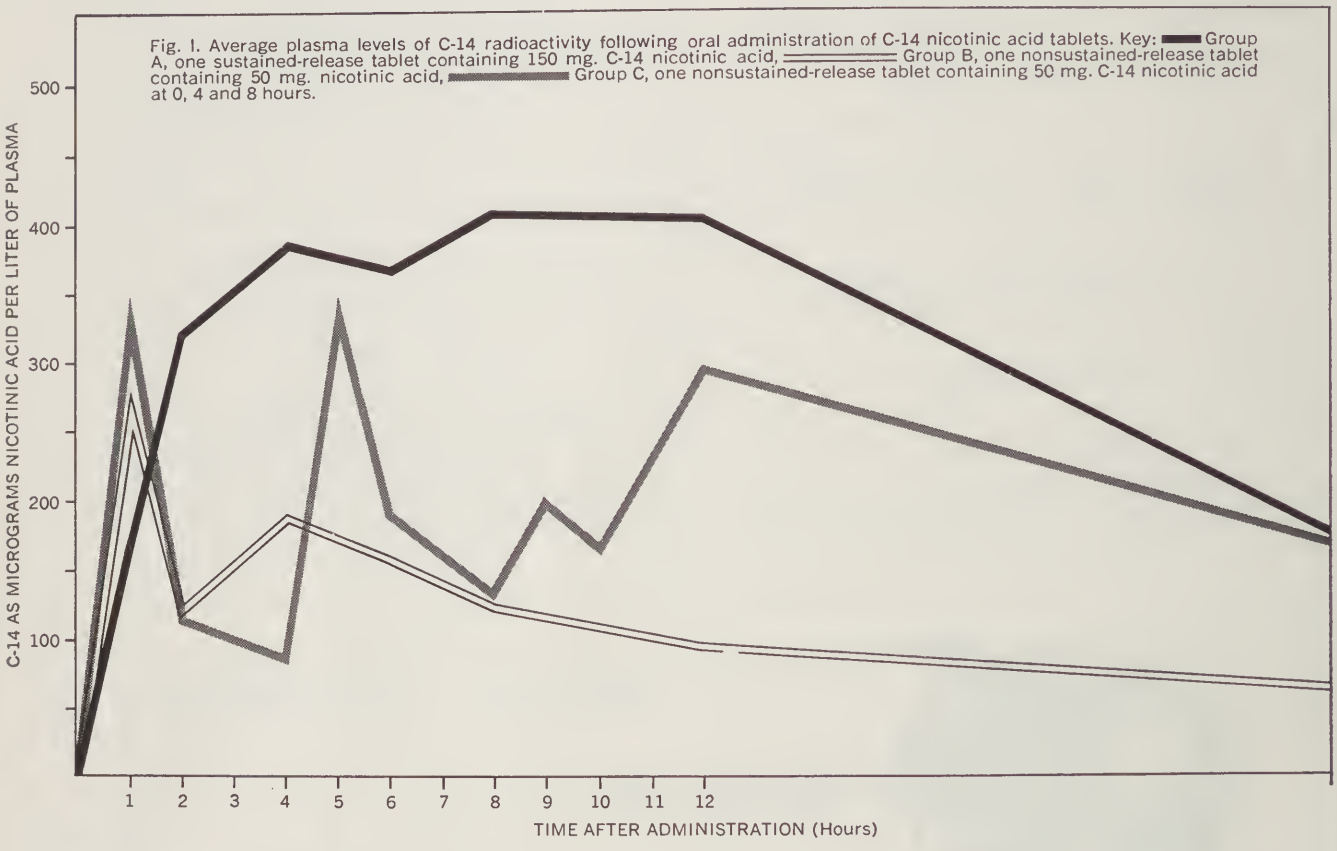
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Fig. 1. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.





(fewer absent doses by absent-minded patients)

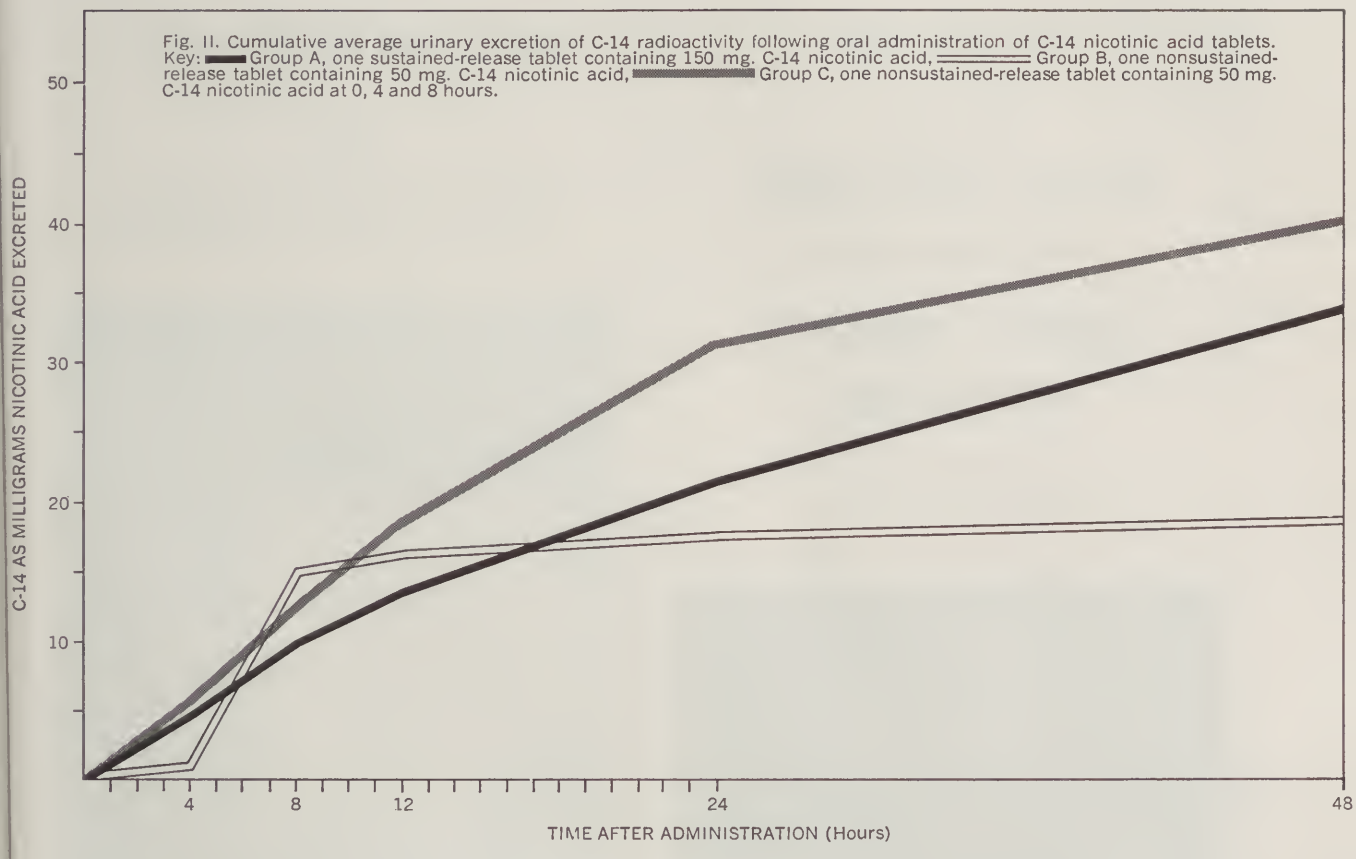
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

ged and debilitated



less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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Tempotrol® Time Controlled Tablet

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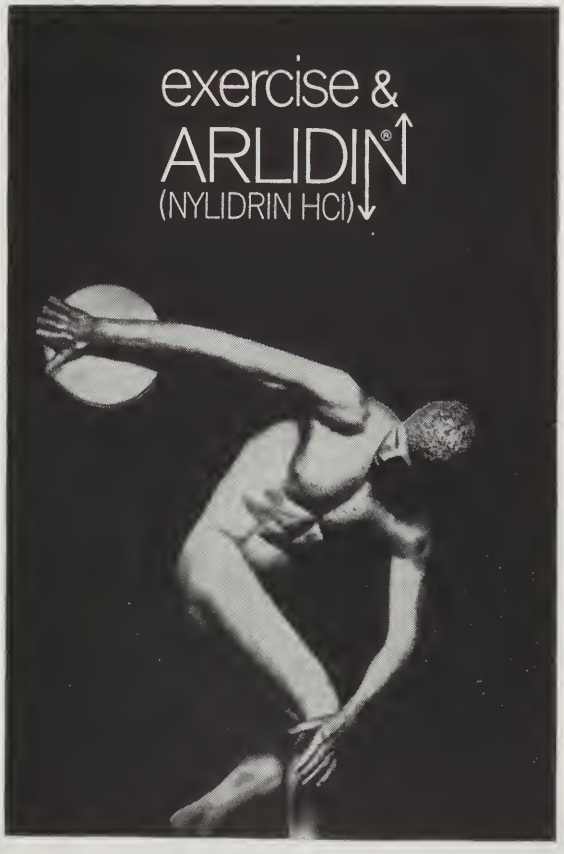
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Baltimore County Medical Association

The Baltimore County Medical Association met at the Baltimore County General Hospital at the kind invitation of the Staff on Wednesday, March 20, 1968. The meeting was called to order by the President, Sidney Venable, Jr., MD. Dr. Venable thanked Irvin Hyatt, MD, and the Staff for arranging the meeting and welcomed Dara Dubash, MD, a new member.

The minutes of the previous meeting were approved as published.



The President speaks—Dr. Sidney Venable, President of the Baltimore County Medical Association, addressed the March meeting. On his left are Dr. Gordon Grau, Past President of the organization and Chairman of the Board of Governors, and Dr. Robert Wilder, guest speaker at the meeting.

Correspondence: A letter was received from Charles O'Donnell, MD, for the plant sent to him while he was hospitalized.

Legislation: It was announced the Commission on Medical Discipline has passed the House and Senate and is awaiting the signature of the Governor. This Legislation will take effect in July, 1969 if approved by the Governor. The Abortion Bill is still in Committee.

Public Relations: Samuel Bacon, Jr., MD, Chairman, announced an article, relative to our meetings, will appear in the *Maryland State Medical Journal* each month. He has contacted the Jeffersonian paper about our Dinner-Dance on March 31st and hopefully will have a photographer present for pictures.

Program Committee: Theodore Patterson, MD, announced the April meeting will be at the Sheppard-Pratt Hospital, the May meeting will be at the Hilltop Inn and the June meeting at the Penn Hotel. The Woman's Auxiliary will be invited to attend the meeting.

The following applications were approved for membership: Emilio Trujillo, MD, Ercolini Gresia, MD, Maurice Berman, MD, Eli Breger, MD, Alberto Montes, MD, and Julian Goldberg, MD. Associate membership was granted to Raymond Bahr, MD, and James Patrick Flynn, MD.

Congratulations to Stanley Bociek, MD, who has been elected to President of the Staff of the Maryland General Hospital.

James Peterman, MD, announced the American Social Health Association will be mailing questionnaires in July requesting the Physicians to report all cases of Venereal Disease during the months of April, May and June.

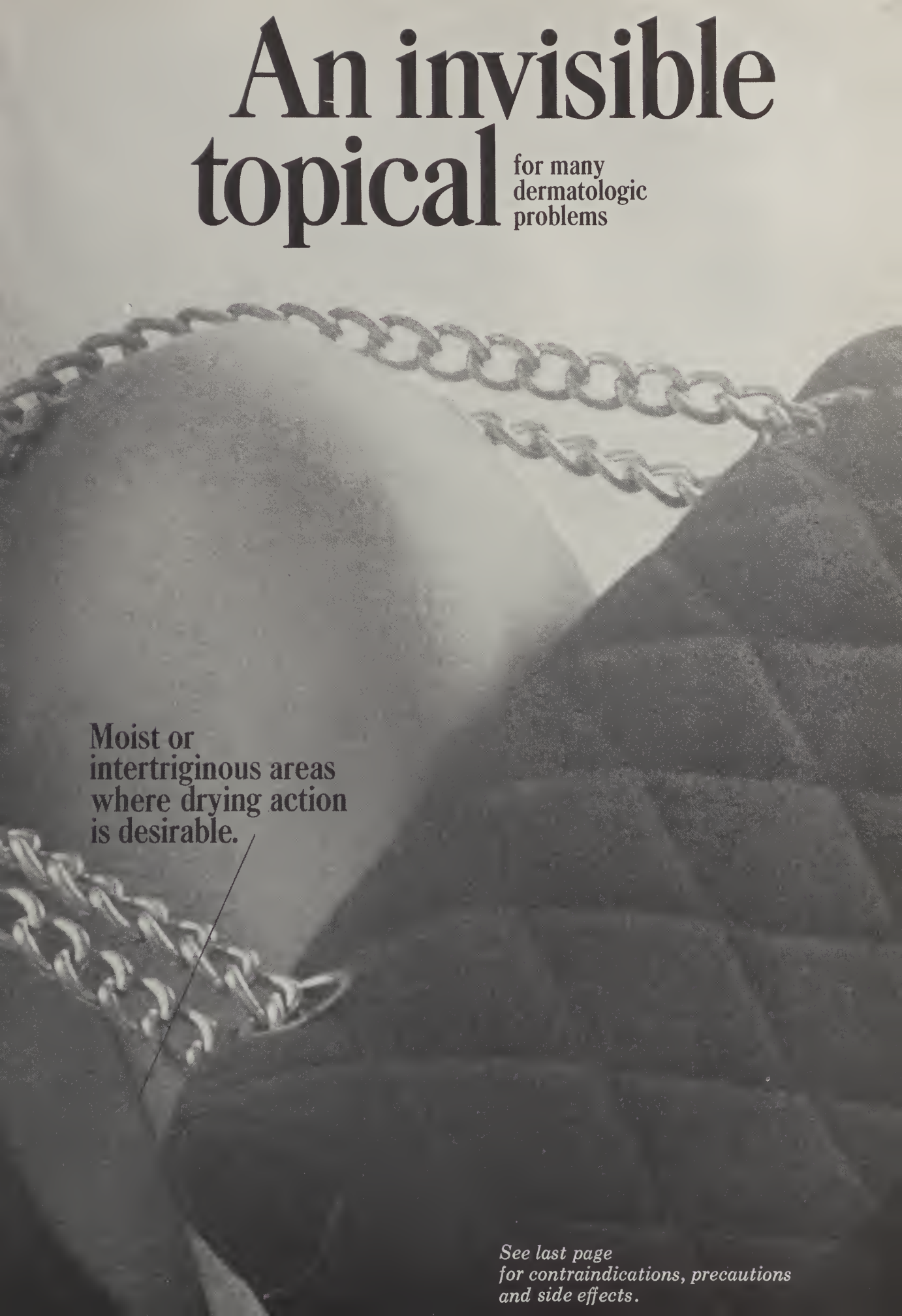
Robert Wilder, MD, well-known Thoracic Surgeon, gave a very interesting talk on "Pacemakers—Past and Present." He demonstrated this with slides and actual pacemakers which had been removed from patients.

Samuel N. Bacon, MD,
Chairman—Public Relations


Hairy sites where creams and ointments do not spread or penetrate readily.
Exposed areas where cosmetic considerations are important.

An invisible topical

for many dermatologic problems



Moist or intertriginous areas where drying action is desirable.

See last page for contraindications, precautions and side effects.

Structurally unique topical steroid in propylene glycol vehicle produces rapid response in many dermatoses.

Synalar Solution produces rapid antiinflammatory, antipruritic action through its unique topical corticosteroid, fluocinolone acetonide. The propylene glycol vehicle provides additional benefits for therapy at problem sites where it is difficult to achieve contact between the lesion and medication—or where creams or ointments may make the lesions worse. Synalar Solution has proved particularly valuable in the symptomatic treatment of seborrheic dermatitis of the scalp, nasolabial folds, eyebrows, ears, and in flexural folds such as the axillae, inframammary, umbilical and anocrural areas. It has also been reported to achieve excellent results in the adjunctive management of atopic dermatitis, contact dermatitis, neurodermatitis, nummular eczema, psoriasis, and sweat retention syndromes in these problem sites.

Penetrates the hairy sites.

In many areas of the body, hair gets in the way of treating the underlying dermatitis. The propylene glycol vehicle of Synalar Solution permits penetration and dispersion at sites where creams and ointments do not readily penetrate. May be applied without matting of hair.

Ideal for moist or intertriginous areas.

Propylene glycol is strongly hygroscopic and is especially useful where sweat retention is a problem. Its low surface tension permits easy spreadability in difficult-to-treat body areas. A number of studies have also shown that propylene glycol has inherent antimicrobial activity.



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anced topical corticosteroid.

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components.

Precautions: In some patients with dry lesions, the solution may increase dryness, scaling, or itching. Application to denuded or fissured areas, such as genital or perianal sites, may produce a burning or stinging sensation. If this persists and dermatitis does not improve, discontinue medication. Although propylene glycol has antiseptic activity, there should be careful initial evaluation and follow-up of infected sites. Incomplete response or exacerbation of lesions may be due to true infection, which requires susceptibility testing and appropriate therapy. On the other hand, saprophytic or low grade infections may clear spontaneously under the influence of Synalar Solution alone. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

Side Effects: Side effects are not encountered ordinarily with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions.

Availability: Synalar (fluocinolone acetonide) Solution 0.01% in a propylene glycol vehicle with citric acid as preservative. 20 and 60 cc. plastic squeeze bottles. *Also available:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream—5, 15 and 60 Gm. tubes.

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Solution
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An invisible topical





Methods for Reimbursing

Following a directive in a recent Health Message from the President, Robert M. Ball, Commissioner of Social Security, announced the beginning of an experimental program to find methods of reimbursing hospitals and doctors that will have built-in incentives to efficiency and economy as well as maintaining a high level of quality care.

"The experiments," the Commissioner said, "are expected to develop ways to get more value for the dollar spent on health care and will be applicable in reimbursing hospitals and doctors under Medicare and other federal health programs.

"Participation in the experiments by hospitals and other health care institutions, by physicians, and by organizations and associations, will all be welcome," he stated. "Participation is entirely voluntary and proposals will be evaluated by a panel of experts and the best selected will be used for experimentation."

Participation by governmental organizations and by nongovernmental organizations, such as Blue Cross and Blue Shield plans, group practice prepayment plans, labor management plans, union clinics, and private proposals from providers themselves, will be advantageous. The experiments that turn out favorably may benefit the entire health care system, private as well as governmental.

Under the medicare law, hospitals and other institutional providers of medicare services are reimbursed for their reasonable costs under a

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national reimbursement formula which provides guidelines as to which costs are allowable. The formula has been criticized on the ground that it provides no special incentives for economy and efficiency.

Reimbursement to physicians for services provided medicare beneficiaries is made by insurance carriers under Government contract on the basis of reasonable charges—generally the charge allowed is the customary charge of the physician as long as it is within the prevailing range of charges by other physicians in the locality.

The generally applicable reimbursement principles may be waived for the experimental projects, Ball pointed out, under authorization provided in the Social Security Amendments of 1967, signed into law by President Johnson on January 2.

The Commissioner further stated that guidelines for the use of those who wish to submit proposals for medicare experimentation or experimentation involving medicare and other federal programs may be obtained by writing to Thomas M. Tierney, Director, Bureau of Health Insurance, Social Security Administration, Balto., Md. 21235.

Guidelines for proposed experiments with methods of reimbursements that are primarily concerned with the medicaid and maternal and child health programs should be directed to the Social and Rehabilitation Service, 330 Independence Ave., Washington, D. C. 20201.

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Each tablet contains:

Potassium Iodide . . . . . 195 mg.
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Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

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One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

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Medicine is Career Choice of 767 National Merit Scholarship Semi-Finalists

The practice of medicine continues to be a preferred career choice among the nation's scholastic elite—semi-finalists in the National Merit Scholarship Program—although the number planning to study medicine has declined from a year ago.

This has been revealed by an unofficial AMA study of information contained in the National Merit Scholarship Corporation's catalog listing the 14,000 students honored as semi-finalists in the 13th Annual Merit program for 1967-1968. Academically, all are in the 99th percentile of the nation's graduating seniors.

Of the 10,779 career-decided students, 7% (767) indicated that they seek to become Doctors of Medicine. This represents an appreciable decline from a year ago when 8% (950) indicated medicine as their career choice. An offsetting factor, however, was the fact that last year was a "bumper year" in which 159 more semi-finalists listed medicine as their career choice than did so in the 1965-1966 program.

COMPARISON OF SELECTED SCIENTIFIC AND HEALTH CAREER CHOICES 1967-1968, 1966-1967 & 1965-1966—NATIONAL MERIT SCHOLARSHIP SEMI-FINALISTS*

Career Choice	Number Selecting In 1967-1968 Program	Number Selecting In 1966-1967 Program	Number Selecting In 1965-1966 Program
Physician	767	950	791
Physicist	643	681	506
Scientist (unspecified)	543	480	539
Chemist	352	433	288
Biological Scientist	341	354	266
Psychologist	223	233	136
Biochemist	212	237	144
Physical Scientist	97	82	83
Social Worker	91	97	#
Nursing	84	92	100
Medical Technologist	62	62	60
Veterinarian	56	72	42
Dentist	30	42	35
Pharmacist	29	38	26
Biophysicist	20	26	13
Physical Therapist	18	19	19
Undecided/Unreported	3,221	2,266	4,544
GRAND TOTALS	6,789	6,164	7,592

* Based on an unofficial, non-computerized tabulation of the career choices shown in the National Merit Scholarship Books.

Not included in tabulation made of 1965-1966 semi-finalists.

For the third consecutive year one out of every three semi-finalists indicated a decision to enter medicine or a closely allied field. Twenty-seven percent of all career-decided candidates plan to become either physicians, physicists (643), scientists-unspecified (543), chemists (352), biological scientists (341) or biochemists (212).

If the 3,221 career-undecided or unreported semi-finalists in the 1967-68 program were to make career choices at the same ratio as the 10,779 who have reached their decisions, it would indicate that 996 plan to study medicine. The comparable figure for the 1966-67 candidates was 1,133.

Numbers choosing other professions included in the compilations were physical scientists, 97; social workers, 91; nursing, 84; medical technologists, 62; veterinarians, 56; dentists, 30; pharmacists, 29; biophysicists, 20; and physical therapists, 18.

In April, congratulatory letters from Milford O. Rouse, MD, president of the AMA, were sent to each of the 3,568 semi-finalists planning to enter medicine or an allied field. Included was a copy of *Horizons Unlimited,* AMA's careers handbook.

A slightly varying letter also was sent to the 3,221 students who had not yet decided upon their career choices. It encourages them to investigate careers in medicine and allied fields and invites them to write for a complimentary copy of *Horizons Unlimited.*

This marks the third year this program has been carried out on behalf of the nation's physicians.

COMPARISON OF SELECTED SCIENTIFIC AND HEALTH CAREER CHOICES 1967-1968, 1966-1967 & 1965-1966—NATIONAL MERIT SCHOLARSHIP SEMI-FINALISTS*

Career Choice	Decrease or Increase '67-'68 vs. '66-'67	Decrease or Increase '67-'68 vs. '65-'66	Decrease or Increase '66-'67 vs. '65-'66
Physician	—183	—24	+159
Physicist	—38	+137	+175
Scientist (unspecified)	+63	+4	—59
Chemist	—81	+64	+145
Biological Scientist	—13	+75	+88
Psychologist	—10	+87	+97
Biochemist	—25	+68	+93
Physical Scientist	+15	+14	—1
Social Worker	—6	#	#
Nursing	—8	—16	—8
Medical Technologist	0	+2	+2
Veterinarian	—16	+14	+30
Dentist	—12	—5	+7
Pharmacist	—9	+3	+12
Biophysicist	—6	+7	+13
Physical Therapist	—1	—1	0
Undecided/Unreported**	+955	—1,323	—2,278
GRAND TOTALS	+625	—894	—1,525

* Based on an unofficial, non-computerized tabulation of the career choices shown in the National Merit Scholarship Books.

Not included in tabulation made of 1965-1966 semi-finalists.

** Any interpretation of decrease/increase should take into consideration variations in number of undecided/unreported.

New Technique for Radium Leakage Detection

A low-cost photographic method for detecting leaks in sealed radium capsules and needles with greater speed than can be achieved with currently used techniques has been developed by the Public Health Service's National Center for Radiological Health.

The method is designed to facilitate testing sealed radium sources with sufficient frequency to insure discovery of leaks before radioactive contamination is spread through buildings, storage facilities, and other areas where radium is kept and used.

The photographic leak detection technique, as developed in the Center's Southeastern Radiological Health Laboratory at Montgomery, Alabama, requires only about six minutes for film exposure and print processing. As long as 24 hours may be needed for methods now used.

The photographic technique can be employed to detect point sources of leaking or exposed radium salts in quantities as low as 500 picocuries. Detection of this low level is possible in sources having a total strength of up to 50 mg of radium.

Development of the photographic detection method primarily was the work of Paul H. Bedrosian, PhD, Chief of the Radium Technology Unit at the Southeastern Radiological Health Laboratory.

"The new technique represents a safe, effective system which can be used easily and at relatively little cost to protect physicians, patients, and the general public against a significant source of unnecessary radiation exposure," said James G. Terrill, Jr., Director of the National Center for Radiological Health.

"It should be emphasized that leaks from radium capsules or needles often cannot be detected visually," Mr. Terrill said. "Many sealed sources which appear to be structurally sound, leak invisible and hazardous radiations as badly as obviously broken ones."

The essence of the new detection technique lies in the ability of radiations of alpha particles to interact with a zinc sulfide scintillator to produce light. Registration of the light on high-speed photographic film shows radium capsules or needles to be leaking, since alpha particles cannot penetrate unfractured walls of a sealed source.

Two film exposures are made for each detection procedure. In one exposure, a shield is used which prevents alpha particles from interacting with zinc sulfide but does not prevent passage of beta and gamma radiations. These, therefore, interact with the scintillator. The resulting light is focused through a lens and a well-defined image is formed on the film.

The shield is removed for the second picture so that light from alpha, beta, and gamma interactions with zinc sulfide are registered on film. Comparison of the images on the two films shows the alpha contribution and, therefore, the presence of a leak.

Investigators at the Southeastern Radiological Health Laboratory have found that the photographic method can be used to detect leaks or contamination at various points along the lengths of radium sources. The technique also can be employed to distinguish among sources containing varying amounts of radium and to detect radioactive contamination picked up by wiping a suspected area.



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



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"The danger involved in prescribing dependency producing medication for relief of anxiety lies in the fact that we do not know in advance the dependency proneness of the individual."[1]

A woman who is undergoing the emotional stresses of the menopause may, for the first time, need an antianxiety agent. But she may also be susceptible to drug abuse.

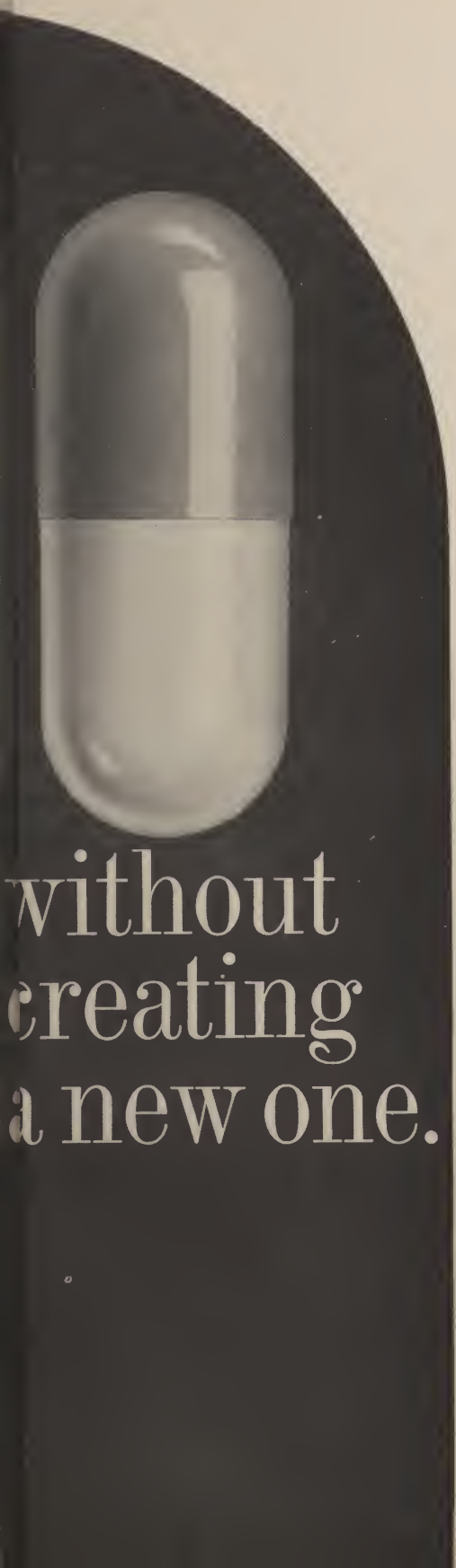
Vistaril can fulfill the need for tranquilization without creating a new need—dependency.

Vistaril calms anxiety and agitation quickly—usually begins to work in 15-30 minutes. And, in more than ten years of clinical use, after more than a billion doses to date, there have been no reported instances of dependency on hydroxyzine.

When the need for antianxiety medication is reduced or no longer exists, Vistaril dosage may be lowered or discontinued without ill effects.

Recommended starting dose, anxious menopausal patient, 50 mg. t.i.d.

With Vistaril, it is as easy to stop therapy as it is to start.



Contraindications: Hypersensitivity to hydroxyzine. The parenteral solution, for intramuscular or intravenous use, *must not* be injected subcutaneously or intra-arterially.

Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit induced fetal abnormalities in the rat at doses substantially above the human therapeutic range. Clinical data in human beings are inadequate. Until adequate data are available to establish safety in early pregnancy, hydroxyzine is contraindicated during this period.

Precautions: Hydroxyzine may potentiate the action of central nervous system depressants such as narcotics and barbiturates. In conjunctive use, dosage for these drugs should be decreased as much as 50%. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. The usual precautions for intramuscular injection should be followed; soft-tissue reactions have rarely been reported when proper technique has been used. Hydroxyzine parenteral solution for intramuscular use should be injected well within the body of a relatively large muscle. In adults, the preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus), or the mid-lateral thigh. In children, preferably the mid-lateral muscle of the thigh. In infants and small children the upper outer quadrant of the gluteal region should only be used when necessary, as in burn patients, in order to minimize the possibility of damage to the sciatic nerve. The deltoid area should be used only if well developed, such as in certain adults and older children, and only with caution to avoid radial nerve injury. Injections should not be made in the lower and middle thirds of the upper arm. Aspiration should be done to help avoid intravascular injection. On reported intravenous injection a few instances of digital gangrene have occurred distal to the injection site, considered to be due to inadvertent intra-arterial injection or possibly periarterial extravasation. Therefore, particular caution (aspiration and site injection) should be observed to insure injection only into intact veins; avoid either intra-arterial injection or extravasation. Intravenous administration should be accomplished slowly, no faster than 25 mg. per minute, and not to exceed 100 mg. in any single dose. In order to avoid possible adverse effects it is recommended that hydroxyzine parenteral solution be diluted to at least 50 cc. with sterile normal saline and administered over a period of four minutes or more, preferably into the tubing of a running intravenous infusion.

The intravenous administration of this drug is not recommended for children under 12 years of age.

Adverse Reactions: Drowsiness may occur; if so, it is usually transitory and may disappear in a few days of continued therapy or upon dosage reduction. Dryness of the mouth may occur with higher doses. Involuntary motor activity, including rare instances of tremor and convulsions, has been reported, usually with higher than recommended dosage.

When this product is given intravenously undiluted, minimal amounts of intravascular hemolysis occur at the site of injection. Giving the maximum recommended intravenous dose (100 mg.) to adults results in immediate transient hemolysis with the liberation of a total of 2-3 grams of hemoglobin, which, in some individuals, can cause small amounts of hemoglobinuria. This compares with the normal red cell destruction from which approximately 8 Gm. of hemoglobin are liberated every 24 hours. If the hydroxyzine is diluted with 50 cc. of normal saline and given during a period of four minutes or more, this phenomenon does not occur.

Supply: Vistaril (hydroxyzine pamoate) Capsules: Equivalent to 25 mg., 50 mg., 100 mg. hydroxyzine HCl. Vistaril (hydroxyzine pamoate) Oral Suspension: Equivalent to 25 mg. hydroxyzine HCl per 5 cc. teaspoonful. Vistaril (hydroxyzine HCl) Parenteral Solution: 25 mg./cc.—10 cc. vial and 50 mg./cc.—2 cc. and 10 cc. vial; Isoject,® 25 and 50 mg. per cc., 1 cc. per unit.

More detailed professional information available on request.

References: 1. Greenhouse, H.R.: Medication and the Dependent Personality, Symposium of Non-Narcotic Drug Dependency and Addiction, The Amer. Psychiat. Assn., N.Y. County Dist. Branch, New York, N.Y., March 10, 1966.

Pfizer LABORATORIES DIVISION
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burning
itching
discharge
of trichomonal vaginitis...

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For the most widespread form of vaginitis the most widely successful therapeutic agent, Flagyl, is clearly indicated.

In trichomonal vaginitis, most physicians have reported a cure-rate of 95 per cent or more with Flagyl when infected male partners are treated concurrently and when treatment is repeated for occasional refractory infections in women.

Among the few patients who do not respond to Flagyl are those who may not have taken the prescribed dosage and those who may have been reinfected.

This high rate of cure obtained with Flagyl is unparalleled. Only systemically active Flagyl reaches the hidden reservoirs of reinfection in male and female genitourinary tracts.

Indications: Flagyl is indicated only in the treatment of trichomoniasis in both the male and female.

Contraindications: Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution: Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side effects: Infrequent and minor side effects include nausea, metallic taste and furry tongue. Gastrointestinal disturbances, flushing and headache sometimes occur, especially with concomitant ingestion of alcohol. The taste of alcoholic beverages may be altered. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness or paresthesia of an extremity, joint pains, confusion, irritability, weakness, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

Dosage and Administration: In women: one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.

In men: When trichomonads are demonstrated, one 250-mg. oral tablet twice daily for ten days in conjunction with treatment of his female partner.

Dosage Forms: Oral tablets—250 mg.
Vaginal inserts—500 mg.

SEARLE

Research in the Service of Medicine

The AMBAR SCRAPBOOK of Obesity Oddities

FACT & LEGEND



GALLSTONES HAVE BEEN FOUND IN 60% OF PATIENTS WHO WEIGH MORE THAN 300 POUNDS, 45% HAVE DIABETES, AND 15-TO-20% HAVE HIGH BLOOD PRESSURE.

SOURCE: DUNCAN, G.G.: SCIENCE NEWS LETTER, 83:403 (JUNE 29) 1963.

NAPOLÉON BONAPARTE

LOST THE BATTLE OF WATERLOO BECAUSE HE WAS TOO FAT!

ACCORDING TO THE NEW YORK TIMES OF APRIL 13, 1890, THE DEFEAT OCCURRED BECAUSE HE FAILED TO CHECK HIS INTELLIGENCE INFORMATION. "IT WAS A MATTER OF MERE INDOLENCE AND THIS INDOLENCE WAS CAUSED BY FAT."

SOURCE: JAMA 186:65 (OCT. 5) 1963.



THE BOOK *"PRAY YOUR WEIGHT AWAY"* URGES READERS TO "ASK GOD TO HELP YOU LIKE EXERCISE" FOR 15 MINUTES A DAY.

SOURCE: REV. C.W. SHEDD: NEW YORK, LIPPINCOTT, 1958.



DIET DROPOUTS

ACCORDING TO DRS. SHIPMAN AND PLESSET "APPARENTLY NO DIETER SUCCEEDS WHO IS VERY ANXIOUS OR DEPRESSED."* THE AMBAR FORMULA PROVIDES **METHAMPHETAMINE** TO HELP **ELEVATE** THE **MOOD** AND **PHENOBARBITAL** TO HELP REDUCE **ANXIETY.**

*SOURCE: ARCHIVES OF GENERAL PSYCHIATRY 8:26 (JUNE 1963).

CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

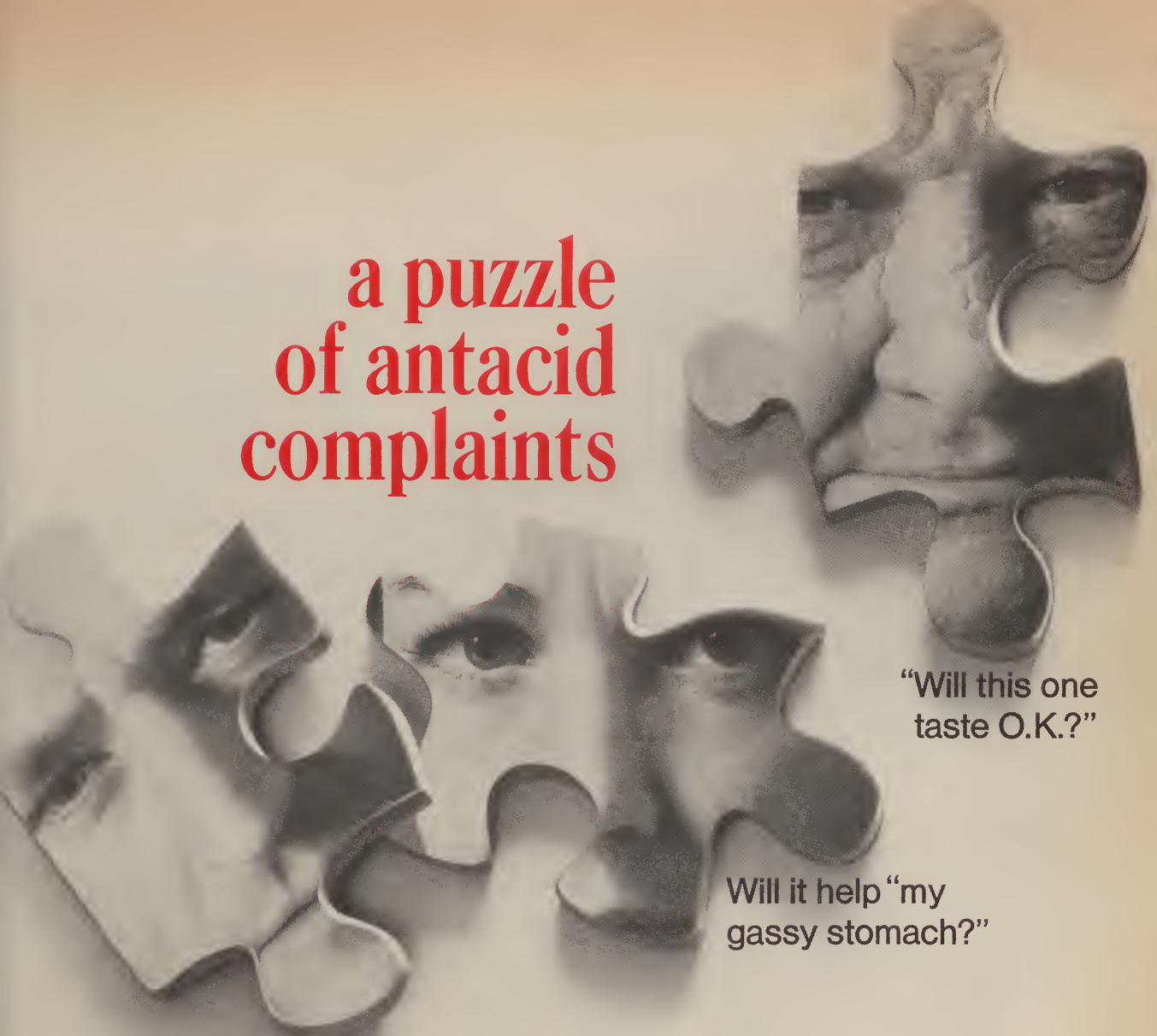
Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

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"Will this one taste O.K.?"

Will it help "my gassy stomach?"

"Will it stop the pain?"

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a solution to peptic ulcer distress

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Concomitant relief of G.I. gas distress—
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Prolonged acceptance confirmed—
in 87.5% of 104 patients after a total of 20,459 documented days of therapy.[2]

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg.
Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

References: 1. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966.
2. Danhof, I. E., Personal communication.

Stuart

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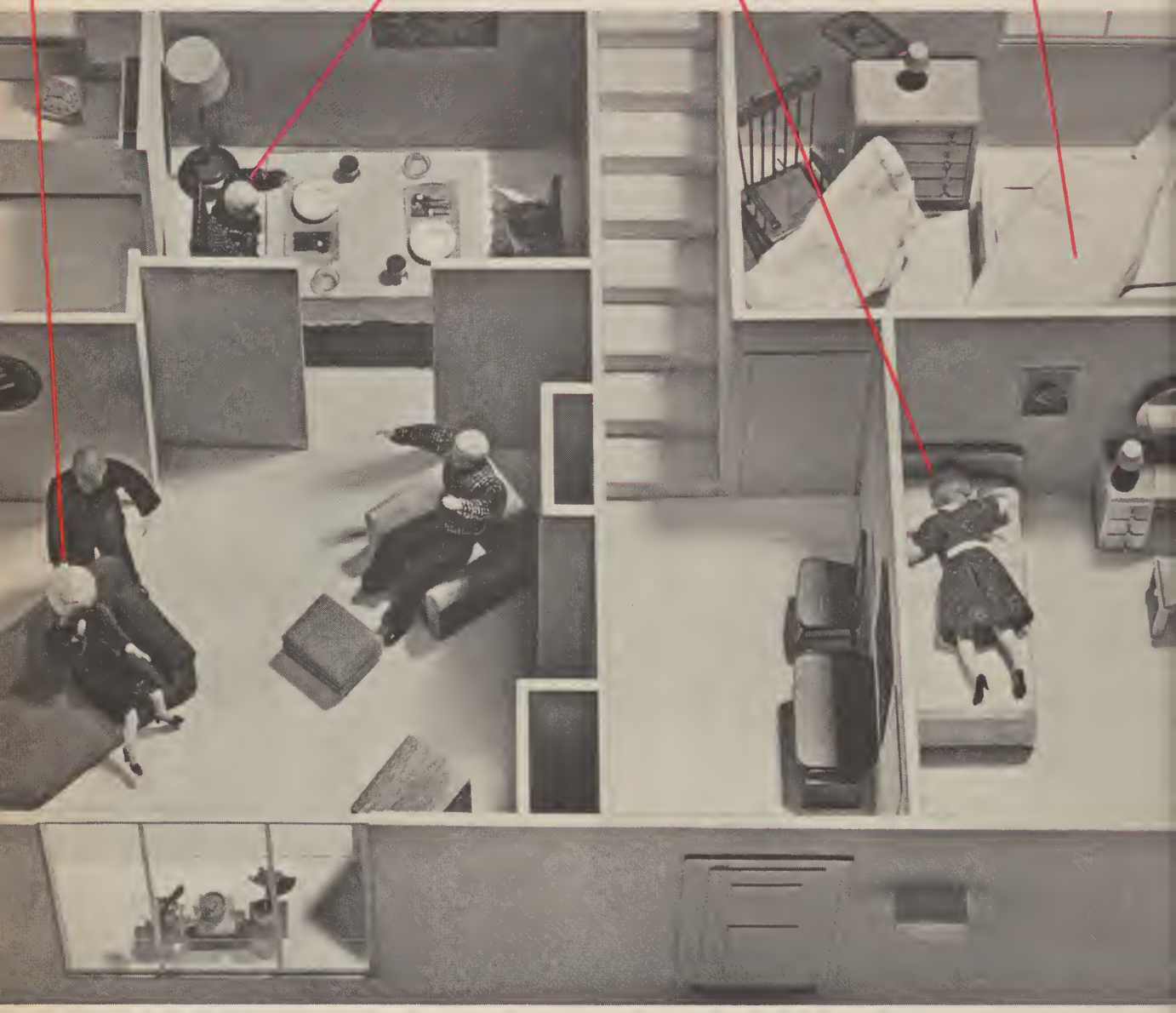
When the agitated geriatric disrupts the home...

His daughter can't please him. There is "just no living with him."

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Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

for moderate to severe anxiety

Mellaril®

(thioridazine)

25 mg. t.i.d.

SANDOZ

Before prescribing, see package insert for full product information.

68-114

Editorial

Maryland State Medical Journal
Vol. 17, No. 5
May, 1968

The "Diet Pill" Scandal: Is an Ethics Committee Review of the Local Situation Needed?

Diet pills, their effects on health in the treatment of the obese have attracted widespread attention across the country recently. While the Food and Drug Administration attacked the manufacturers of weight-reducing pills, Congress listened to hearings on the ethical and legal aspects of physicians and osteopaths who specialize in the treatment of the obese.

As the representative of the medical profession, the AMA was invited to testify before Congress. The testimony reiterated the policy adopted by the AMA House of Delegates last June:

"There is no ethical or legal ruling which would prevent a physician from limiting his practice to the treatment of obesity but this is not a recognized specialty. Since obesity may be only a sign, many disciplines of medicine may be involved in proper treatment."

While the practice of weight-control is ethical and proper, the misuse of medical procedures or the failure to render acceptable medical care to individual patients is to be condemned.

The AMA further directed medical societies to accept as an obligation the protection of the people in the community from physicians who are not practicing medicine's high standards. The obligation of the medical society is to properly review the practices of some physicians who deal primarily or exclusively in the area of weight-control and if conclusive evidence is found, a case should be presented before the Ethics Committee.

Some of the guidelines for preparing cases recommended by the AMA are:

- If physicians engaged in this type of practice are not taking adequate histories, not conducting adequate physical examinations, are over-prescribing, or are prescribing medications which have not been found to be safe and efficacious, then they are guilty of unethical conduct and very probably guilty of malpractice as well.
- Testimony could be received from patients as to the type of practice followed.
- Justification that the accepted practice in the community was of a different nature than the procedure followed would have to be presented before the Ethics Committee.

In August, a group of doctors from the Faculty completed a study of weight reduction programs being conducted throughout Maryland both by lay organizations and physicians. Twelve practices were reviewed by the Mediation Subcommittee for the Study of Obesity and its Treatment and the subcommittee made the following recommendation:

No further investigation into the practice of Bariatrics is believed indicated, at this time, but this is a matter for decision by the full Mediation Committee. Those physicians who have indicated some shortcomings in their current practices should be advised of such shortcomings.

The committee issued a warning to the general public in which it was stated that "The treatment of obesity requires careful medical control and close supervision of patients. It cannot be isolated from concern for co-existing diseases such as diabetes or heart disease. It requires very definite diagnostic skills in which the physician can bring to bear all available knowledge of human physiology, metabolism, and current information on the patient's responses to weight reduction."

Studying and Treating the Obese Patient[1]

A large outpatient study leads to the conclusion that obesity is not a disease but a sign of disease and that metabolic functions often can be returned to normal with intensive medical management. A plan for office management of obesity is advanced on the basis of this hospital study.

NEIL SOLOMON, MD, PhD[2]

There are no clear-cut medical text book answers to the question of the best way of treating obesity. The reason is that obesity is not a disease but the sign of some underlying problem. Whether the problem is purely psychological or physiological or a combination of the two is up to the physician to determine and to treat specifically and appropriately. The doctor best able to perform this duty is the physician who is best acquainted with the patient and the multifactors that affect his total picture. Generally this is the patient's family physician. If after conscientious treatment, the patient manifests "intractable obesity" then the physician may want to refer the patient to an endocrinologist.

Recent newspaper and magazine reports and Congressional inquiries into diet therapy with so-called rainbow pills attest again to society's so-far fruitless search for short cuts in obesity treatment. The desire to have our cake, eat it, and—in the bargin—lose weight has yet to give rise to rational therapy. It may never do so. Drugs may appear to give substance temporarily to the illusion that pills may compensate for persistent feasting. But there is a limit to the effects of amphetamines, phenobarbital, diuretics and other drugs in dampening appetite and otherwise apparently promoting some weight loss. Inasmuch as many obese persons have cardiovascular disease, diabetes, and other conditions, the prescribing of pills and diets with only superficial physical examination and medical assessment, if any at all, undoubtedly is foolhardy. Nonetheless, individuals on "rainbow pills" occasionally have to be hospitalized when their vigorous pursuit of weight loss has been channeled into indiscriminate pill taking. Congress was told of one individual virtually paralyzed after sustained use of excessive thyroid pills. The U.S. Food and Drug Administration has an Illinois coroner's report that 14 deaths *may have been due* to "diet pills."

The price of the pill-taking illusion is high in disappointment and morbidity. Reality, however, carries a high price. Physician and patient must be tenacious in the face of the manifold challenges of obesity—medical, psychological and social. The physician must commit his own talents and the resources of others in support of the patient. And the patient must forego many gustatory pleasures, learn how and what to eat, and form attitudes that will prevail the rest of his life.

The purpose of the Baltimore City Hospital study was to demonstrate in a large outpatient population that tenacious employment of diet, biochemical monitoring, and the physician's expertise in frequent consultations with the patient

1. This investigation was supported in part by USPHS research grant #FR33, from the General Clinical Research Centers Branch (DRFR, National Institutes of Health).

2. Dr. Solomon is associate professor of physiology and assistant professor of medicine at the University of Maryland, assistant chief of medicine at Baltimore City Hospital, instructor in medicine at Johns Hopkins University, and Consulting Endocrinologist for the Veterans Administration.

will work over the long haul to stabilize weight at healthy values. After five years of a study expected to continue for a lifetime, 217 of 541 obese outpatients have been brought to ideal weight and have maintained it for at least two years. Another 191 patients are losing but have not reached ideal weight. Some 133 patients have dropped from the study and are classified as treatment failures.

The rationale of the treatment approach described derives from characteristics of the obese population. This is not a small group in American life; 1 in 5 Americans is overweight, that is, more than 10% over the ideal weight shown in Table 1. An obese population has an unusual concentration of afflictions. At Baltimore City Hospitals, where the study of the outpatients is conducted, 260 of the 541—nearly half—had one or more of the conditions listed below, the number of patients with a condition being given parenthetically:

Diabetes mellitus (183), arthritis (127), heart disease (87), gout (75), hypertension (61), kidney disease (52), hypercholesterolemia (44), hernia (41), thyroid disease (29), colitis (15), peptic ulcer (7), cancer (3), and other conditions (27).

TABLE 1

Ideal Weight—Women

(For girls sixteen to twenty-seven subtract one pound each year until age twenty-seven. For women, sixty to seventy years, subtract ½ pound each year during this time.)

See next page for Ideal Weight—Men.

Height Without Shoes	Small Bone Structure	Medium Bone Structure	Large Bone Structure
4′8″	95 lbs.	101 lbs.	111 lbs.
4′9″	97 lbs.	104 lbs.	114 lbs.
4′10″	100 lbs.	107 lbs.	117 lbs.
4′11″	103 lbs.	110 lbs.	120 lbs.
5′0″	106 lbs.	113 lbs.	123 lbs.
5′1″	109 lbs.	116 lbs.	126 lbs.
5′2″	112 lbs.	119 lbs.	129 lbs.
5′3″	115 lbs.	123 lbs.	133 lbs.
5′4″	118 lbs.	127 lbs.	137 lbs.
5′5″	122 lbs.	131 lbs.	141 lbs.
5′6″	126 lbs.	135 lbs.	145 lbs.
5′7″	130 lbs.	139 lbs.	149 lbs.
5′8″	135 lbs.	143 lbs.	154 lbs.
5′9″	139 lbs.	147 lbs.	158 lbs.
5′10″	143 lbs.	151 lbs.	163 lbs.
5′11″	147 lbs.	155 lbs.	168 lbs.
6′0″	151 lbs.	159 lbs.	173 lbs.

Compared to control subjects with which they were matched for age and sex, the obese outpatients had a far greater incidence of metabolic derangements, as shown in Table 2. Those more than 50% overweight had a 50-50 chance of having an underlying medical abnormality requiring treatment. At 30% overweight, the likelihood of having such an abnormality was less but still significant. This justifies a physician's having a high index of suspicion of disease in the obese person.

Less than 10% of the obese outpatients had a bona fide medical abnormality that caused their obesity in the first place. The metabolic derangements referred to in the preceding paragraph and in Table 2, while not first-instance causes of obesity, can be regarded as effects of chronic overeating that confirm or promote obesity. Regardless of the cause of obesity, an obese population has an increased prevalence of morbidity and, as various studies have shown, higher mortality rates than the general population.[1] In fact, mortality and morbidity rates increase in direct proportion to the degree of obesity (Fig. 1).

Behaviorally, the outpatients also differed in significant respects from control subjects of normal weight. Of the 541 outpatients, 400 reported that they over-ate when under stress, such as facing an examination, losing a job, arguing with relatives, or hearing bad news. By contrast, the control subjects and 750 of 1,000 non-obese visitors and others queried at random in a hospital said they tended to undereat when stressed.

Most of the obese outpatients had a history suggesting deficient oral gratification in infancy, either insufficient nursing at the breast, insufficient bottle time, or colic. They tended to meet a need for oral gratification by eating (and eating sweets primarily) as well as by smoking cigarettes, pipes,

and cigars. That obesity itself may spur this search for oral gratification may be inferred from the finding, noted above, that obese persons have diminished taste-bud discrimination. Apparently, obese persons do not get enough stimulation from normal amounts of food.

Obesity has marked effects on an individual's psychophysiological performance. My colleagues and I studied 12 obese patients in depth at The Johns Hopkins Hospital, University Hospital of Maryland, and Baltimore City Hospitals. As an example of the psychophysiological decrements found, we will describe performance characteristics of a 30-year-old man who, at 350 lbs., was 100% overweight. Compared to the average performance of 30-year-old men observed in a longitudinal study of aging at the Gerontology Research Center of the National Institute of Child Health and Human Development, located at Baltimore City Hospitals,[2-12] the individual in our study had

TABLE 1

Ideal Weight—Men

(For boys sixteen to twenty-seven years of age, subtract ½ pound for each year under twenty-seven. For men, sixty to seventy years of age, subtract ½ pound for each year between ages sixty and seventy.)	Height Without Shoes	Small Bone Structure	Medium Bone Structure	Large Bone Structure
	5′1″	116 lbs.	123 lbs.	133 lbs.
	5′2″	119 lbs.	127 lbs.	136 lbs.
	5′3″	122 lbs.	130 lbs.	140 lbs.
	5′4″	125 lbs.	133 lbs.	143 lbs.
	5′5″	128 lbs.	136 lbs.	147 lbs.
	5′6″	132 lbs.	140 lbs.	151 lbs.
	5′7″	136 lbs.	145 lbs.	156 lbs.
	5′8″	140 lbs.	149 lbs.	160 lbs.
	5′9″	145 lbs.	153 lbs.	164 lbs.
	5′10″	149 lbs.	157 lbs.	169 lbs.
	5′11″	152 lbs.	162 lbs.	174 lbs.
	6′0″	157 lbs.	166 lbs.	178 lbs.
	6′1″	161 lbs.	168 lbs.	181 lbs.
	6′2″	163 lbs.	170 lbs.	183 lbs.
	6′3″	165 lbs.	176 lbs.	188 lbs.
	6′4″	169 lbs.	181 lbs.	193 lbs.
	6′5″	172 lbs.	186 lbs.	199 lbs.

TABLE 2

Incidence of Abnormal Tests in 100 Obese Subjects and 100 Matched Controls at Beginning of Study

	% Abnormal	
Carbohydrate Metabolism	**Obesity Group**	**Control Group**
2 hr. post prandial glucose (>120 mgm%)	37%	2%
Glucose tolerance test, abnormal	63%	5%
Protein Metabolism		
Uric Acid (>6.0 mgm%)	28%	2%
Fat Metabolism		
Free fatty acids (>0.75 mEq./liter)	73%	14%
Steroid Metabolism		
17-Ketogenic steroids Male>25 mgm per 24 hrs. Female>20 mgm per 24 hrs.	58%	1%
Thyroid Function		
Thyroxine-by-column (<3 mgm%)	9%	2%
Basal metabolic (<-—10)	18%	2%
Photomatogram	30%	6%
Food Intolerance	96%	31%

the following percentages of normal function: (These results were not calculated as a function of weight.)

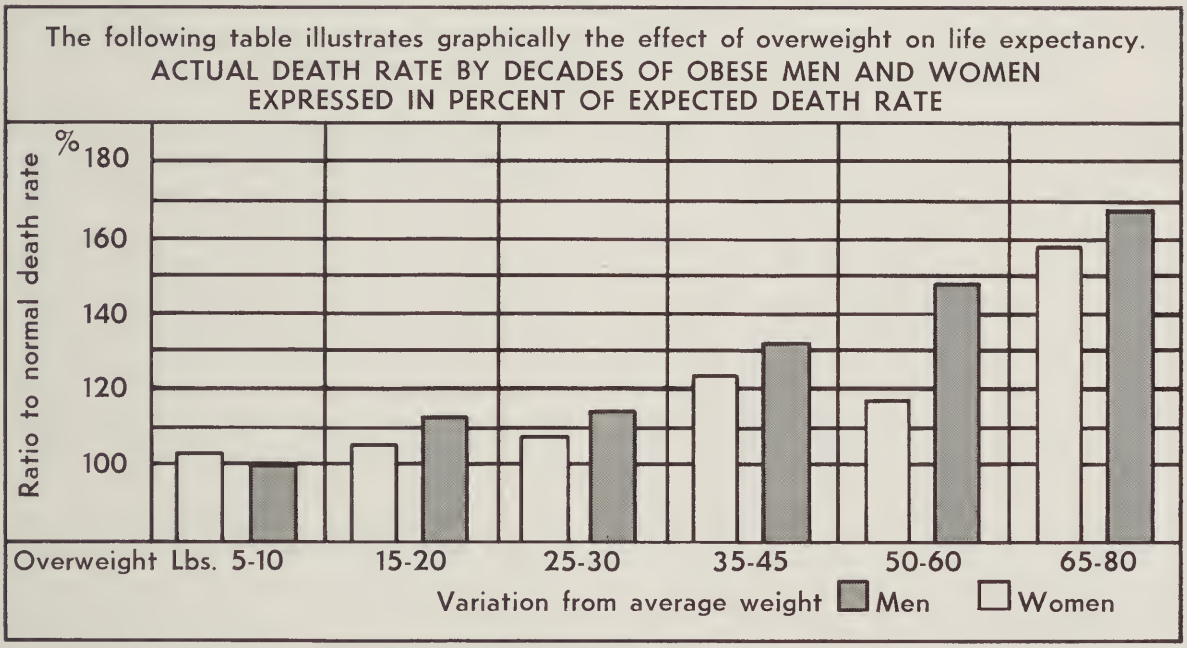
Speed of response on simple psychomotor test, 44%
Cardiac output at rest, 60%
Maximum ventilation on exercise, 25%
Maximum breathing capacity, 25%
Taste bud discrimination, 33%
Maximum work rate, 15%

His psychophysiological profile was startlingly like that of healthy 70-year-old men observed at the Gerontology Center. And average life expectancy for obese persons of this type is 15 years less than that of his normal age peers. From the standpoint of these decrements, obesity may be regarded as a form of premature aging.

This information is conveyed to patients so they may apprehend the hazards of obesity. On the positive side, they are told that as weight is reduced and maintained at normal values, morbidity risks also return to normal proportions. The in-depth studies showed that functional decrements in the 300 lb. man and the other eleven subjects were reversed with weight loss. The outpatient studies pointed in the same direction. In addition, as Table 3 shows, the obese group after one year of treatment resembled the healthy control group in selected indicators of metabolic performance. It appears that there are few concomitants of obesity that cannot be reversed in most patients. (One that cannot be reversed appears to be bagginess of the skin; loss of elasticity seems to be a permanent feature of long-term obesity, although exercise affords some improvement.)

As a prelude to discussing treatment, an elaboration on the relationship of metabolic derangement to obesity is necessary. What is offered is basically speculative. Clinicians are familiar with what our laboratory coined the "Yo-Yo Syndrome," exemplified by the patient who cyclicly loses weight and regains all of it and more. His weight goes up and down, repeatedly. A possible explanation is that an important metabolic capacity is weakened or exhausted while the patient is overeating. Then when he cuts back his caloric intake, his body is unable to metabolize certain foods properly. An analogous situation is illustrated by the diabetic who must decrease his carbohydrate intake because of an absolute or relative deficiency of insulin.

FIGURE 1



The natural history of some hormonal or enzymatic exhaustion in obesity remains to be well documented, but observations in diabetics may indicate a possible approach to study. In some hereditary predestined diabetics increased sugar intake evokes an increased insulin response until the beta cells of the pancreas can no longer keep pace with the high insulin demand. If the overload has persisted too long, the insulin secretion mechanism may be deranged permanently and/or the tissues which are targets of insulin may become

TABLE 3

Incidence of Abnormal Tests in 82 Obese Subjects and 59 Matched Controls After One Year on the Study

	% Abnormal	
Carbohydrate Metabolism	**Obesity Group**	**Control Group**
2 hr. post prandial glucose (>120 mgm%)	5%	2%
Glucose tolerance test, abnormal	13%	5%
Protein Metabolism		
Uric Acid (>6.0 mgm%)	2%	2%
Fat Metabolism		
Free Fatty Acids (>0.75 mEq./liter)	16%	10%
Steroid Metabolism		
17-Ketogenic steroids Males>25 mgm per 24 hrs. Females>20 mgm per 24 hrs.	24%	0%
Thyroid Function		
Thyroxine-by-column (<3 mgm%)	0%	0%
Basal metabolic rate (<—10)	11%	2%
Photomatogram	7%	7%
Food Intolerance	48%	33%

less sensitive to it. Our observations of endocrine response in progressive obesity suggest that a similar pattern may be present.

Something akin to this may happen enzymatically. The output of the enzymes that split fat may decline in response to persistent "overtaxation," and the patient will lay down fat even on a very low calorie diet. Our laboratory has preliminary data to suggest that 20% of the obese patients studied by the TTZ—Pyocyanine Assay Technic [13]—had reduced blood titers of the liver enzyme butyrl Co-A dehydrogenase which is involved in the oxidation of butyrl Co-A to crotonyl Co-A which is one link in the oxidation of fatty acids. Lack of the enzyme results in a decreased breakdown of fat.

At the moment, it is a chicken-and-egg proposition; whether a particular case of obesity begins with a weakness in the hormonal-enzymatic apparatus or whether obesity induces the weakness. Most probably in the great majority of cases obesity occurs because of overeating. Obesity breeds more obesity in a snowball effect as hormonal and enzymatic systems are broken down in striving to support the enlarged organism. Our laboratory is trying to locate where overloads and failures are likely to occur in the chains of enzymatic and hormonal actions necessary for healthy metabolism. We anticipate such information will permit us to establish profiles of vulnerability to obesity and to pinpoint how obesity snowballs.

The assembling of the study population of 541 patients was begun in 1963. Physicians referred patients with intractable obesity. They were accepted only if they were sufficiently motivated and agreed to continue in the study until ideal weight was attained and stabilized. Most of the patients were from 10 to 100 lbs. overweight, though several were more than 300 lbs. overweight. Seventy-three percent were women and 27% men. By age, the group included 15 aged under 15, 24 aged 15-20, 271 from age 20-45, 219 aged 46-65, and 12 over 65.

Most of the patients studied had been to "weight reduction doctors," who for one reason or another, had not sought or found the medical conditions associated with their obesity. Application of a diet in ignorance of these conditions or indiscriminate use of medication without an adequate history, physical examination, and laboratory tests, is a prescription for failure and even potentially hazardous to the patient. Ideally, the physician should have a complete study of the blood including a hemogram, arterial and venous carbon dioxide, thyroxine-by-column, glucose tolerance, serum electrolytes, cholesterol, urea nitrogen, liver function studies, uric acid, urinary steroids (17 hydroxy and 17 keto-steroids) and qualitative and quantitative amino acid analyses. An electrocardiogram, chest, and skull films should also be obtained. The skull film is included to check for pituitary lesions, such as an eroded sella turcica (found in 2 of the 541 outpatients).

The studies, in addition to a comprehensive history which emphasized personal, family and dietary data as well as a thorough physical examination, were the basis for the treatment of obesity.

In discussions with the physician, the patient was told the progress or lack of progress he was demonstrating in terms of weight reduction and laboratory test results. Dietary adjustments were made depending on medical and laboratory findings and the patient's reaction to his diet. A patient who said he had to have a particular food would be told how to adjust his intake to make "room" for the otherwise proscribed food. A patient who had to have a snack after supper was instructed on how to compensate in his regular meals.

The patient was told that the name of the game was "fewer calories in, more calories out" and was encouraged to exercise. The patient with no weight loss was asked to identify his problem in adhering to the diet. We conveyed our concern with his disappointments as well as satisfaction with his progress. The fact that patients were counseled at every appointment by a physician may have helped them to confirm the seriousness of the weight-reduction attempt.

We do not hesitate to tell patients that anyone who keeps to the diet must lose weight, barring an undetected abnormality. Some "crutches" are offered. The patient can obtain oral gratification at low caloric cost by chewing sugarless gum or drinking fruit flavored diet drinks. Motivation can be helped along by calling the patient's attention to improvements in his condition. Ideal weight and ideal measurements become a goal toward which the patient can see his own progress. Changes in physique are reinforcing for both women and men. Again and again, patients are told that the reward of being able to eat normally awaited their achieving ideal weight and that failure to make progress tended to prolong the risks of obesity. Despite counseling and crutches, some patients could not stay on a diet. Actually, most of the failures dropped out of the study after one or two visits, some voicing resentment that "no magic pill or shot" was offered to do the weight-reduction job for them. It was generally found that the greater the amount and duration of obesity, the less likely was the chance for success. From this plan and the outpatient findings, our laboratory found a means of reconnoitering obese patients for possible treatment in the physician's office practice. The comprehensive history and physical examination, of course, are essential no matter where treatment is given. As a simplified set of screening tests, suggest (1) thyroxine-by-column to determine the titer of thyroid hormone in the blood; (2) two-hour postprandial glucose to determine the level blood sugar; (3) venous carbon dioxide levels as a check for CO_2 retention secondary to extreme hypoventilation; (4) serum uric acid level because of the propensity toward hyperuricemia, in obese patients; (5) serum cholesterol because of the high incidence of hypercholesterolemia associated with obesity; (6) hematocrit, because of the anemia secondary to fad diets; (7) complete urine analysis especially noting any protenuria or ketonuria and (8) respiratory function, simply tested by asking the patient to pucker his lips and blow out a match burning six inches away.

Combined with findings in the history and physical examination, these laboratory procedures provide the physician with a sound basis for prescribing indicated medications, diet, and exercises for most obese patients. The patient should be checked at intervals the physician judges frequent enough to maintain motivation, to keep track of the medical conditions and to establish and secondarily re-inforce good nutritional habit pattern. Where progress is satisfactory, appointment interval maybe lengthened. If despite good eating discipline the obesity proves intractable in the office approach, the patient may require more elaborate observation and treatment as a hospital outpatient in the hands of an endocrinologist with more sophisticated laboratory procedures at his command.

Our final comments are directed to physicians who treat the young. An obese baby is an obese adolescent, an obese adult, and an obese parent whose eating habits spread to his children. Prevention of obesity is essential. The pediatrician may be the professional person with the earliest chance of counseling parents against establishing patterns of overeating in their children. The outpatient study indicates that the desire to eat sweets often stems from an early age when the parent typically offered candy to comfort or bribe a child. In doing so, the parent lit the fuse of obesity. Physicians treating obesity in a parent or future parent may very well be preventing perpetuation of obesity in the young and future generation.

A complete list of references will be supplied upon request.

Basic Mechanisms of Transient Ischemic Attacks

The true incidence of transient cerebral ischemic attacks in the general population is not known, but the significance of this phenomenon can be appreciated from the fact that roughly half of patients sustaining permanent neurological deficit from completed extracranial vascular occlusion have experienced transient ischemic attacks for up to six months prior to the catastrophic event.[1] Symptoms may last only seconds or minutes. The patient may minimize them and the physician overlook them when the neurological examination proves negative.

Accurate diagnosis and rational, meaningful therapy of transient cerebral ischemia begins with a high index of suspicion on the part of the physician and an understanding of certain basic mechanisms involved in the production of cerebrovascular insufficiency.

It seems logical then to begin a discussion of basic considerations in transient ischemic attacks with a workable definition which at once delineates the problem and provides insight into the underlying nature of the process involved.

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A transient ischemic attack is defined as a temporary dysfunction of one or more parts of the nervous system, without permanent damage to neural tissue, resulting from a temporary discrepancy between the metabolic requirements and the metabolic supply to the tissue concerned, this occurring, at least in part, on the basis of disease of the cardiovascular system. The neurological symptoms and findings with which the patient presents are specifically referable to those areas in which such dysfunction occurs.

Having defined cerebral ischemia in these terms, let us now consider further those factors which are involved in maintaining the balance of metabolic supply and demand in normally functioning brain tissue.

The metabolic supply of any area of the brain is determined 1) by the amount of blood perfusing that area and 2) by the metabolic content of the blood itself.

The average human brain, while comprising less than 2% of the body weight, receives roughly 15% of the cardiac output or nearly 800 cc of blood each minute. Blood flow in the brain, as in any other vascular bed, is determined by the pressure gradient from the arterial to the venous side divided by the resistance across the vascular bed.

$$CBF = \frac{P_a - P_v}{CVR}$$

Arterial blood pressure is the product of the cardiac output times the total peripheral vascular resist-

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ance, and cardiac output is in turn the product of ventricular stroke volume times the heart rate. Since it is axiomatic that the amount of blood flowing to the brain is of necessity a percentage of the total cardiac output, it is not difficult to understand why, given a patient with prexisting narrowing of a cerebral vessel, reduction in the cardiac output secondary to myocardial infarction, cardiac arrythmia, myocarditis, severe bradycardia or congestive heart failure, might, and frequently does, present with symptoms and signs of cerebral ischemia referable to that vessel. Likewise, reduction of the total peripheral vascular resistance, such as occurs in shock or with the injudicious use of hypotensive agents, also serves to reduce the perfusing arterial pressure and may result in insufficiency of cerebral blood flow, particularly in areas predisposed by local cerebrovascular disease.

Cerebrovascular resistance is a complexly determined and as yet poorly understood factor in the regulation of cerebral blood flow. Generally speaking, however, cerebrovascular resistance is a function of 1) the rheological properties of the blood and 2) the surface area of the vascular bed-arteries, arterioles, capillaries, venules and veins. Under normal circumstances, it is the cerebral arterioles which contribute most actively to vascular resistance. The constriction or dilatation of these small vessels is therefore thought to be of great importance in the local regulation of blood flow in the brain, since it is by this mechanism that the radius of vessel is altered. Of equal importance is the maximum size of the vascular lumen and the condition of the endothelium lining it. In the presence of pathology of the vessel itself—be this subendothelial plaque, syphilitic panarteritis or collagen vascular disease—narrowing of the lumen results in increased vascular resistance with reduction of blood flow through that vessel. Roughening or disruption of the smooth endothelial lining predisposes to thrombosis. The rheological properties of the blood in cerebrovascular disease have not been thoroughly evaluated, and the role of such factors as blood coagulability have not as yet been studied in transient cerebral ischemia. In certain conditions, such as polycythemia, sickle cell disease and marcoglobulinemia, the effects on blood viscosity and flow properties are obvious factors contributing to reduction in blood flow.

Obstruction of blood flow to brain tissue can occur anywhere from the great vessels in the thorax to the smallest ramifications of the vascular tree in the brain parenchyma itself. In the extracranial portion of this vascular pathway, ie the carotid and vertebral arteries, stenosis and occlusion occur most commonly at the bifurcation of the common carotid into its internal and external branches and at the origin of the innominate, common carotid and subclavian—vertebral complexes from the aorta in the superior mediastinum. Existing studies on the incidence of stenotic lesions in the great vessels of the upper chest and neck are both interesting and informative. In the Mayo Clinic series of 100 unselected autopsies wherein these vessels were studied,[2] 40% of persons over the age of 50 years had 50% or more occlusion of one or more of the great vessels. Stenosis occurred most commonly at or near the point of origin of the great vessels from the aorta. Gurdjian et. al [3] in angiographic studies of a population of 772 patients with an admitting diagnosis of cerebrovascular disease, found that 167 or 23% had internal carotid arterial stenosis by arteriography and that in these stenosis occurred bilaterally in 65. In another 78 or 10%, internal carotid occlusion was complete and in 9 patients total internal carotid occlusion was bilateral. In another series, Faris et. al [4] performed transbrachial arteriograms on 43 healthy males between ages 40 and 65 years. Twenty-three or 53.6% had arterial lesions, 17 of these in the right carotid, and 10 or 23.2% had lesions in more than one artery. Faris and coworkers found only a slight difference, not statistically significant, between the incidence of arterial lesions in this asymptomatic group and a second group of 68 patients of comparable age with cerebrovascular insufficiency and clinical neurological findings.

These studies point to two conclusions about which we can be reasonably firm. Firstly, stenosis of the great vessels occurs frequently in the general population. Secondly, stenosis occurs in persons who never have clinical manifestations of cerebrovascular disease sufficiently severe to bring them to the attention of the medical profession, as well as in patients with cerebrovascular disease of varying degrees of clinical severity and morbidity.

Such studies suggest that with significant stenosis or even complete occlusion of cerebral vessels, yet another factor, that of collateral circulation, is of critical importance. Collateral circulation to brain tissue occurs 1) in the circle of Willis, 2) between branches of vessels over the surface of the brain and 3) with branches of the external carotid circulation that penetrate intracranially. No anastomoses between vessels occur inside the

brain parenchyma until the level of the precapillary and capillary.[5] Collateral pathways by which one vessel may perfuse the territory usually supplied by another insufficient or occluded vessel are very much subject to congenital anomalous variation as well as to the ravages of disease process.

In the presence of adequate collateral circulation, the patient may experience transient dysfunction or, indeed, no dysfunction at all with reduction of blood flow through a given artery. With poor collateral, the same reduction may well result in permanent dysfunction and death of neural tissue. One can, if one wishes, look upon the entire cardiovascular system simply as the means by which blood is delivered to the capillary. And in this context, the blood may be regarded simply as the vehicle by which metabolites are delivered and waste products carried away from the cells subserved by these capillaries. In addition, then, to the multiple factors concerned in the perfusion of brain tissue by the cerebral blood flow per se, the second consideration of major importance in dealing with cerebral ischemia is the metabolic content of the blood.

The metabolism of neural tissue runs almost exclusively on two substances—glucose and oxygen. The average adult brain in the basal state avariciously consumes 77 mg of glucose and 49 ml of oxygen or 20% of the total oxygen consumption of the body each minute. Furthermore, neural tissue is exquisitely sensitive to deficiencies in its metabolites and, in response to oxygen lack or reduction in available glucose, may do one of two things. It may reduce or stop entirely its normal function or it may become hyperexcitable, the best known clinical example of which is the convulsive phenomenom.

Fortunately, there is a built-in safety margin in the brain with respect to blood flow.[5] Cerebral blood flow may be reduced by up to 50% without occurrence of symptoms, this due to the apparent ability of brain tissue to extract more oxygen than it usually does, as reflected in the jugular venous oxygen concentration, under these circumstances. Beyond this critical level of flow, however, further reduction in flow, barely altering the oxygen uptake, results in dramatic, catastrophic changes in neural function.

Transient reduction in serum glucose or in the oxygen content of arterial blood, such as may occur in lobar pneumonia, may play a role in the etiology of neurological dysfunction in patients with focal involvement of cerebral vessels. Likewise, a reduction in the innate oxygen-carrying capacity of the blood secondary to anemia may be a significant factor.

Because of the singular metabolic requirements of the brain persistence of reduced blood flow, oxygen and/or glucose levels from any cause in the absence of adequate collateral circulation, results in infarction and death of neural tissue in the area concerned. In transient ischemic attacks, by definition, the discrepancy between metabolic supply and demand does not persist long enough to produce permanent damage and the patient recovers from his transient dysfunction. It is to this group of patients, therefore, that adequate measures of diagnosis and treatment are most profitably directed.

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A Specialty in Search of Identity*

Over the last few years, the number of patients with chronic diseases (other than the mental diseases) requiring hospital care has increased alarmingly. The number of physicians dealing exclusively with such patients has increased particularly in municipal, state and federal hospitals. Although the physician dealing with such patients must be prepared to care for patients with acute diseases, it is apparent that certain special knowledge is required to give good medical care to patients with chronic diseases. It is our purpose here to look into the origin of some of these older specialties now found to be essential to the hospital care and rehabilitation of patients with chronic diseases.

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Psychosomatic Medicine

This special area of knowledge focuses on the interaction of psychological and physiological aspects of all normal and abnormal bodily functions. Although recognition of the interactions of psyche and soma goes back into antiquity, it was not until 1939, with the founding of the periodical *Psychosomatic Medicine* and the publication of Weiss and English's textbook (of the same name in the same year) that this speciality gained formal recognition among physicians.

Unfortunately the recognition that psychological factors are of primary importance in the care of patients with chronic diseases has not resulted in actual application of this knowledge.[1] One recent observer made the following indictment: "In spite of the fact that continuous references are made in hospitals to the necessity of 'meeting patient's psychological needs,' action seems to be predominantly confined on medical and surgical services to repetition of this admonition."[2]

Psychosocial Medicine

Psychosocial Medicine deals with the social factors which may influence people emotionally and intellectually. Possibly these reactions were first noted among soldiers. During the Revolutionary War, a disease called "nostalgia" in which the patient became depressed, passive and weak was described. It was particularly noticed among new recruits.

During the American Civil War, DaCosta's syndrome (which was also a type of neurasthenia) was noted widely among the troops. During World War I "soldier's heart" was described by a number of observers. In World War II, a popular diagnosis was "situation reaction" designating the many emotional responses arising in the setting of war and army life.

Adolph Meyer was one of the first to emphasize the social and culture environment of mental disease in the civilian population. He was interested not only in the social factors which shape the

* *This is the first of a series of notes on "Rehabilitation of Chronic Impairments in Adults."*

social goals and habit patterns of the individual patient, but also in the communities and social settings which influence the production of psychiatric disorders in certain populations. He recognized social "sore spots" such as alcoholic and syphilis-producing communities. He emphasized the effect of communities with "insufficient hygiene of work and recreations" which are even now being identified among the urban slum dwellers.[3]

The hospital also has been associated with depersonalization of the patient, fractionation of service and loss of ideal patient-physician relationships. Interest in this field has been centered largely in mental hospitals. The impact of the hospital environment, the hospital hierarchy, the nurses and other patients on the sick person has been shown to be of substantial importance in the outcome of the patient's management.[2,4] Some studies have placed emphasis on social and cultural forces at work,[5] others on psychological considerations.[6] The use of the hospital as a therapeutic environment has been best developed in mental hospitals,[7] but can be extended to General Hospitals [2] as well as to Departments of Rehabilitation.[8]

The strategy of changing the environment of hospitals, in the interest of improved medical care, has been discussed in a number of excellent publications.[2,9,10]

Patient Care Research

This unlikely name is applied to the study of the personnel, institutions, organization, administration, financing, payment, economics and objectives of the entire system of health services.[11] Formally organized in Atlantic City in May of 1961 by physicians interested in rehabilitation and hospital out-patient clinics, its purposes have rapidly become clarified; it has been accepted as a sub-section of the American Federation for Clinical Research, and has had several national meetings. Spurred on by federal government involvement in payment of health programs and by full-time physicians with heavy teaching and patient care responsibilities, this new movement shows promise of upgrading the academic acceptability of caring for patients, illuminating and guiding the administration of health services, as well as increasing our knowledge of ecology and medical sociology.

Physical Medicine and Rehabilitation

Physical Medicine originated as a specialty in Physical Therapy Departments and at Spas. The preoccupation was with physical modalities such as heat, water and diathermy. The inclusion of muscle testing and exercise was necessitated because of the large number of patients with poliomyelitis treated in Departments of Physical Therapy. Next came the emphasis on activities of daily living, vocational rehabilitation and home evaluation.

The concept of reconstruction enunciated by Billings [12] in 1919 does not differ greatly from the present day concept of rehabilitation except that it is now widely applied to civilians and children:

> "The policy of the medical department for the physical reconstruction of disabled soldiers, and later extended to disabled sailors and marines, was formulated on August 9, 1917, applied in some of the general military hospitals early in 1918, and approved by the War Department July 29, 1918. (Physical reconstruction is defined as) continued management and treatment carried to the fullest degree of maximum physical and function restoration, consistent with the nature of the disability, by the employment of all known measures of modern medical management, including physical therapy, manual and mental work and recreational play."

As the concept of rehabilitation has enlarged from a third phase of medicine centered in a rehabilitation hospital to a bedside attitude, potentially needed by all types of patients, it has been captured by other specialties such as orthopedics, psychiatry, neurology, plastic surgery, speech and hearing, by physicians expert in these specialties. The successful invasion of the field of rehabilitation by a number of other specialists has increased the importance of the physiatrist in teaching and in developing new techniques of wide application, as well as working with special rehabilitation problems in the rehabilitation hospital. The new concept of rehabilitation is well expressed by Bonner.[13]

> "Rehabilitation of the chronically ill and disabled is not just a continuous series of restorative technics and procedures but actually a philosophy of medical responsibility."

Geriatrics

Sir John Floyer published his text *Medicina Gerocomica* in 1724, but a specialty of Geriatrics was not seriously urged until the 1940's. *Geriatrics* and the *Journal of Gerontology* were started in

1946 and the *Journal of the American Geriatrics Society* in 1953.

Many geriatricians are concerned with the care of institutionalized elderly patients and are intimately concerned with the complications of arteriosclerosis, neoplasms, prostatic disease, "chronic brain syndrome," as well as the family and social problems of the elderly. Other physicians, often dealing with ambulatory elderly patients, feel that geriatrics is becoming the heart of internal medicine.

In Great Britain, particularly, the specialty of Geriatrics has been highly developed to deal with the large numbers of elderly patients coming to the hospitals.[14]

Chronic Diseases

The first issue of the *Journal of Chronic Diseases* in January, 1955, noted that one-half the patients with chronic diseases are under 45.[15] Two points were made: First, that much that could be done for patients with chronic disease was not at present being done and that more research was needed in the natural course of disease. Secondly, the Journal editors expressed their interest in *prevention* as being the logical approach to chronic diseases. They expressed their interest in the beginnings rather than the end stages of chronic disease, thereby differentiating their interest from that of Geriatrics.

Medical Sociology

It is apparent that all the above mentioned trends are more or less sociologically oriented in a far more sophisticated manner than was evident in medical care even a decade ago. The number of sociologists interested in health problems is increasing. The *Journal of Health and Human Behavior,* started in 1960, deals with social factors in health and disease. A growing body of literature deals with the physician or the hospital as a sociological phenomenon.[16, 17] In addition, there are innumerable publications on government financing of medicine and socialized medicine in various countries.[18] These purely sociological treatises, however, are beyond the intent of this article. There is an excellent summary of recent trends of sociology and social work in relation to health in Paul Lazarsfeld's *Uses of Sociology.*[19]

Comprehensive Care

This movement in medical care is much more vague than some of the specialties mentioned above. Sometimes the word "comprehensive" is used to designate psychiatric or psychosomatic clinics on the theory that the use of the words "psychiatric" or "psychosomatic" might scare the patient away.

Generally, however, the term is used to infer that all specialties, techniques and facilities are available and applied as needed to each patient. In addition to the usual medical disciplines; physical, occupational, speech and hearing technicians, social service, psychological and vocational testing, and visiting nurses are generally involved. Facilities for acute care, surgery, rehabilitation, chronic care, and home care programs are understood to be available.[20]

This type of care is appropriate for patients with multiple medical, psychosomatic, social and vocational impairments of a chronic nature.

Some authors[21] have emphasized the importance of integration of existing community facilities in the rendering of good medical care.

One group of workers has denied categorically that the team approach is the essential feature in comprehensive medicine. Where the team is needed, it should be used. Comprehensive medicine is patient rather than disease oriented. "Comprehensive Medicine, then, is the conviction, born out of experience, that the medical care of patients can be improved now by the utilization of psychodynamic knowledge and sociological knowledge, along with generally available biological skills."[20]

Specialties often arise in universities with emphasis on theory—understanding—analysis—narrowness—deepness. This is important for an academic-research approach to rehabilitation, but our emphasis in these notes will be toward treatment—practicality—simplification—synthesis—breadth.[22] Our major beliefs are as follows:

☐ **The rehabilitation movement is an attempt to emphasize an important aspect of medicine which in the past has often been neglected. We will emphasize *performance* of the patient as a central preoccupation and goal in medical care. Rehabilitation is concerned with physical, mental, social and vocational *performance.* Although diagnosis is the necessary beginning point of medical care, the logical aim is maximal performance in all spheres of human activity.**

☐ **The increasing number of elderly patients, patients with complex social problems, patients with automobile and industrial injuries, calls for comprehensive evaluation using para-medical personnel and social agencies to bring about maximal performance.**

☐ Rehabilitation is not a separate third stage of medical care but is an essential ingredient of every doctor-patient encounter.

☐ Although there are patients who need the special facilities of a rehabilitation center and the skilled care of a physiatrist, the great bulk of rehabilitation must be carried on by the patient's personal physician or a specialist who is not primarily a physiatrist.

☐ There is growing interest, in response to the growing need, in classification of patients into functional categories based on what the patient is able to do for himself. These classifications are now being widely used in patients with heart disease, chronic obstructive pulmonary disease and arthritis. Criteria for classifying patients' performance are important and are being emphasized.

☐ Finally, we would plead with all our power that rehabilitation is not an isolated endeavor: It should not be isolated geographically; it should not be isolated intellectually into anybody else's specialty; it should not be isolated temporally into a third stage of medicine. In brief, rehabilitation is best given at the place where physician and patient meet, by the physician, now. The physician is not required to supply all the patients' medical needs alone: He must recognize areas which may need further investigation and treatment by people skilled in these problems. Throughout his care of the patient, the physician must be neither merely a technician nor a coordinator; he must maintain major concern for the patient as a person.

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Your Medical Faculty at Work

JOHN SARGEANT

Executive Secretary

The Council of the Medical and Chirurgical Faculty of the State of Maryland at its March 28, 1968, meeting took the following actions:

1. Rescinded 1967 dues for one physician and reinstated him to membership at the request of his component society.
2. Rescinded 1968 dues for three members on account of illness and in accordance with Article III, Section 7, of the Faculty Bylaws; all at the request of the individual component societies.
3. Recommended Emeritus Membership to the House of Delegates for three members, all at the request of the Component Society involved.
4. Ratified Physicians' Defense for several members who had requested it.
5. Heard of the dismissal of three cases, all without any payment by the physician concerned.
6. Regretted its inability to provide defense for one physician who requested it. This was because of late payment of dues for the year in which the alleged offense occurred.
7. Adopted a recommendation of the Finance Committee that the funds available in the Coggins Building Fund be invested in securities managed by the T. Rowe Price Company.
8. Also heard from the same Committee that the current balance in the Educational Fund was $67,200; and the value of the Faculty's current investment portfolio was $954,823 as of December 31, 1967.
9. Adopted the following recommendation of the Professional Medical Services Committee:

   "That payment for Title 19 patients for professional services rendered patients in in-patient and in outpatient departments of hospitals be made on the basis of Usual, Customary and Reasonable fees until such time as the funds appropriated for these purposes are deleted.

   "It is also expected that services will not be withheld by physicians when such a point is reached. However, it should be understood that physicians will continue to submit bills even though payment may not be received for those services rendered to patients who have been certified by the State agency as being eligible for medical care services for whom the State under its Medical Assistance Program has assumed full financial responsibility."

   It was made clear that this adoption of a position does not involve the home and office visit program.

10. Adopted the following recommendation of the Occupational Health Committee:

    "The Medical and Chirurgical Faculty of Maryland supports the principle that industry requiring pre-employment chest X-rays should be encouraged to contract with a private Radiologist whenever possible. The Health Department and the Maryland Tuberculosis Association should discourage the use of their facilities by industry for pre-employment X-rays where it is felt that such an arrangement with a private Radiologist is feasible."

11. Adopted a unanimous decision that the Governor should be asked to veto House Bill 574, which requires physicians to prescribe generically in all "grant" programs operated by the State Health Department.
12. Approved support of the AMA position on HR 14816, the Occupational Safety and Health Act of 1968; and approved sending letters to Maryland's Congressional Delegation advising them of this.

13. Considered at great length a position in connection with the Title 19 (Medicaid) program and adopted the following:

"The Council of the Medical and Chirurgical Faculty of the State of Maryland, at its January, 1968, meeting stated it would clarify at its meeting in March, 1968, its position in regard to the Medicaid program, after the conclusion of the 1968 General Assembly session.
"Inasmuch as the Governor and the Legislature have failed to meet their obligations to those citizens for whom the State has assumed financial responsibility, by not appropriating sufficient funds to provide for their medical care, the Council cannot endorse either the present or proposed Medicaid program."

14. Requested the appropriate Faculty representatives to meet with their counterpart representatives in other groups providing services under the Medicaid program; and to prepare comments on the report of the Ad Hoc Health Planning Committee to the Governor for transmission to the Governor and the Committee.
15. Declined to lend the Faculty's name to a proposal to sponsor a press conference dealing with armor vests and battle helmets used by U. S. Armed Forces personnel in Viet Nam.
16. Agreed to take a stand against House Bill 274, a Hospital Licensure Law and request the Governor to veto it.
17. Approved the principles contained in a statement dealing with a Health Manpower Study to be discussed at a Subcommittee meeting in connection with a proposed Third Medical School in Maryland.

Semiannual Meeting

of the

Medical and Chirurgical Faculty of Maryland

September 6th and 7th

Ocean City

Watch for further details

TUBERCULOSIS SECTION

A Service of the Maryland Tuberculosis Association

Ever since the demonstration of a bacillus as the cause of tuberculosis there has existed a strong and universal fear of the disease as being highly contagious. Along with this an elaborate system of precautions to protect the healthy individual from infection has developed.

Infectiousness of Tuberculosis

Within the past 20 years the advent of effective chemotherapy, more precise knowledge of the mechanism of transmission, and practical ways of disinfecting the air have minimized the risk of infection. But the attitudes toward contagion and the practices used in handling tuberculosis patients have not kept pace.

It has seemed appropriate, therefore, to re-evaluate present practices in the light of current knowledge and experience.

The tubercle bacillus is a non-motile organism which is readily killed by heat, drying, sunshine and ultraviolet light. It is transmitted from one person to another by air in the residues of minute droplets of moisture produced during coughing, sneezing, laughing, etc. The larger particles fall to the ground close to the expeller. The small ones, however, rapidly evaporate, leaving "droplet nuclei" which remain suspended in the air indefinitely and are carried by air currents as is cigarette smoke. Inhalation and implantation on lung tissue of these bacillus-laden droplet nuclei are necessary for transmission to be completed.

As a rule, only the more minute particles are able to penetrate into the lungs. When larger particles are inhaled, they are stopped in the nasal and upper respiratory passages and eliminated. Even though laden with tubercle bacilli, these particles do not infect because the upper respiratory tract is resistant to infection. Bacilli must reach the susceptible lung tissue, settle out, survive and multiply before infection develops.

Available evidence suggests that tubercle bacilli lodged on fomites—linen, furniture, books, and floors—do not constitute a significant infection hazard. Most of them die quickly through the action of drying, heat, or sunlight. Dried secretions are very difficult to fragment and suspend in the air, and furthermore, those airborne particles which do arise from surfaces are ordinarily innocuous. They are too large to penetrate into the lung. Hand washing is efficient in removing organisms possibly picked up from fomites or direct contact with infectious sputum or other discharges.

Breaking the chain of transmission of bacilli from person to person has two aspects: 1. prevention of contamination of the air, and 2. elimination of contamination once it has occurred. Simple, inexpensive procedures can accomplish both of these objectives.

Prevention of Contamination

This requires preventing the known case of tuberculosis from excreting bacilli into the atmosphere. The most effective tools for achieving this are:

Chemotherapy. The antituberculosis drugs ordinarily reduce the cough and sputum of tuberculosis patients within a matter of days. Within a few weeks the excretion of tubercle bacilli is usually halted. Chemotherapy is thus very effective in reducing the hazard of transmission of tuberculosis from the patient to others. The occasional patient with drug-resistant organisms constitutes a special problem since he may continue to excrete tubercle bacilli.

Covering of Nose and Mouth by the patient when coughing, raising sputum, sneezing, laughing, etc. This is an effective procedure for preventing atomized secretions from becoming airborne. Thus the transmission chain is broken at its source. Of course, all raised sputum should be expectorated into tissues, placed in special containers and burned, or flushed into the sewerage system.

Decontamination

The aim of decontamination is to remove from the air any tubercle bacilli excreted by the patients into the air. Decontamination should be applied particularly to places where people with unknown or unsuspected tuberculosis are apt to be present. This includes emergency and admitting rooms of general hospitals and clinics. It also includes rooms used by patients until their chemotherapy has become effective.

Ventilation. The concentration of organisms in the air of a room and hence the likelihood of inhaling them are reduced if the room is well ventilated. Good ventilation is recommended but is ordinarily much slower than ultraviolet light in reducing the concentration of airborne organisms.

Ultraviolet light. The use of ultraviolet lights is an additional valuable procedure for disinfection. Studies have shown that the air of tuberculosis patients' rooms can be rapidly made noninfectious by irradiation with ultraviolet light. Techniques for checking the sterilizing efficacy of an ultraviolet installation are now available. Ultraviolet lights should be used in rooms which are likely to be frequented or occupied by patients with undiagnosed or unsuspected tuberculosis, and by diagnosed patients in the early phase of chemotherapy; and in air ducts when air is being recirculated.

Such installations are effective not only against tubercle bacilli, but also against other organisms responsible for intra-hospital infections.

Gowns and Masks

The use of gowns by personnel as isolating mechanisms in airborne infections such as tuberculosis is ineffective and not called for. Neither are masks indicated for personnel except in instances of intimate face to face contact. If anyone is to be masked, it should be the patient. Masking him is indicated only if his condition is such that he is unable to control or unwilling to cover his cough.

Non-pulmonary Tuberculosis

Since the discharges from body area afflicted with non-pulmonary tuberculosis do not become airborne, the danger of infection from such sources is remote. Of course, if active pulmonary tuberculosis is also present, the principles outlined are applicable.

The Undiagnosed and Unsuspected Case of Tuberculosis

It should be made clear that the greatest risk of infection arises from the individual with undiagnosed or unsuspected tuberculosis. A very important safeguard for hospitals in this situation is a consistent program of tuberculin testing and chest X-raying of all employees who may be subject to exposure, and of all hospital admissions.

Prepared by the NTA Ad Hoc Committee on Treatment of TB Patients in General Hospitals.

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Approved May 21, 1967, by the NTA Committee on Guidance of the Tuberculosis Program and the American Thoracic Society Executive Committee. Accepted by NTA Board of Directors on May 27, 1967.

ALCOHOLISM SECTION

"Prevention and Treatment of Alcoholism: Impracticable—Low Priority Program"*?

"The private physician, through organized medical societies, can play a key role in the development of a sound program for alcoholics. A leadership role is available for the medical profession. The question now before us is 'Are we ready and willing to accept the challenge?' "[1]

As of now, we are not. Physicians are too plainly absent from the groups that have labored with chronic alcoholics. Even "the community, or at least its public health officials, has paid no attention" to the problem.[2] Why this apparent neglect?

JOHN B. De HOFF, MD, MPH
Assistant Commissioner of Health
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Public health heads reluctantly into a sea of troubles as it takes on what is called control of alcoholism. Most good control measures prevent or slow disease development. In chronic alcoholism, though, it is not control but it is treatment. Treatment of homeless, penniless men and women with little hope and little motivation; treatment of others who may have homes and some money, but with whom other therapists have failed. Little wonder that public health agencies shy from undertaking a venture with high patient volumes, heavy total program costs, low recovery rates and conflicting community expectations.

In the past, governments have given their health agencies sizeable budgets to deal with acute and communicable diseases that immediately threatened a community, or to manage chronic diseases that needed long-term care in isolation or protective custody. Chronic alcoholism by definition might easily fit into the latter class.

Patients with chronic diseases went to institutions in which they often got inexpensive and inexperienced care, where they got out of the public scene, and where they occasionally got well. High admission and low discharge rates led to higher occupancy rates and to greater total costs. Budgets were cut or pared by reviewers who knew the price of everything but the value of nothing. Although good chronic care centers today have strong rehabilitation and community involvement elements, it was not always so. In the short run, it may have seemed better to let these institutions remain as storehouses, holding merchandise for occasional re-issue after repair work had made it workable again.

Hazards like these still face public health's new alcoholic rehabilitation units—hazards which arise from an as yet poorly understood chronic

* Mytinger, Robert E., DrPH: "Mandates for Change in Local Health Departments," Public Health Reports 81:437-448, 1966.

illness. Past experiences with similar centers warn of troubles which may result from underbudgeting, from staffs with too little training or inadequate numbers, and from the community's failure to remain involved and concerned with the people who suffer from this condition. In the long run, without good rehabilitation practices and effective preventive efforts, these types of curative or caretaking centers are more costly than even their budgets indicate.

Several sets of conditions helped public agencies virtually eliminate certain costly illnesses. Each of the conditions listed below has more than once met strong and bitter opposition by patients, community groups or even by physicians. Judge for yourself if these techniques can work to control alcoholism now.

- A clear disease definition helps in diagnosis, proves it to authorities, and identifies it to the patient and to friends and strangers as a grave and imminent threat to the community. Everyone concerned with these diseases has been trained to impose or accept stringent sanctions such as separation, isolation, and vigorous treatment, for the general good.

- Carefully conducted research shows close cause and effect relations which can easily be interrupted. Contaminated and infected water supplies carry typhoid or cholera. Mosquitoes from unpleasant puddles carry malaria or yellow fever. Personal desires may override any control measures, as in venereal diseases.

- Public agencies can apply a simple inexpensive procedure, or require that it be applied to all persons regardless of socio-economic status. No individual is singled out for this attention, and indeed he may unknowingly receive the remedy. Chlorination or fluoridation of water supplies, or mandatory vaccination against smallpox, are examples.

- When conditions such as ophthalmia neonatorum, congenital syphilis, poliomyelitis and phenylketonuria affect true innocents, the public compassionately responds with laws or dollars needed for control.

- Acute disease states have no advantages for the sick person or for any others. The patient may suffer some permanent damage or even die, his family is disturbed and may also become ill, and his employer must carry on without him or with an inexperienced substitute.

Alcoholism, unfortunately, has few characteristics of diseases which public health measures control so well. It is not a clearly defined illness. Patients and doctors avoid the diagnosis and acute general hospitals avoid the patient. A clear cause-effect relationship has not been generally accepted. No simple remedy or prophylaxis is at hand. Patients derive some advantage from the illness. Both merchants and government profit from sales of alcoholic beverages. Alcoholism is not recognized by other citizens as contagious. And, lastly, the alcoholic is seen as weak willed and as responsible for his own plight.

Recent court decisions directly affected Maryland (U.S. Court of Appeals, fourth circuit) when they held that public drunkenness is no longer a crime but a concern of the health professions, private and public. Here is a new field wherein experience gained from research and work in preventable disorders of organized communities qualifies medical professionals for a position of leadership. Good administration by public health officials will follow a familiar path: Define the local problem, measure its intensity and distribution, identify factors which affect it significantly, and evaluate forces at hand to cope with it. With the problem described and the opposing forces estimated, the health agencies then select an attainable goal.

Although care and treatment of chronic alcoholics seems a reasonable objective today, many problem areas need clarification if we are to proceed from therapy to true control. Among them are the role of alcohol in alcoholism, possible carrier states in such an illness, ambivalent therapists and administrators (and almost everyone else involved with alcoholism, for that matter), and the personal physician's approach to his chronically alcoholic patient.

As long as definitions of alcoholism stress impaired social functioning, damaged health or lost control over consumption, alcohol itself is overlooked as a causative factor. Although causative factors in alcoholism include others than alcohol, it can safely be said about an individual that if he never drinks alcohol he will not become an alcoholic. He may be depressed or anxious or ill in other ways, but he will not be an alcoholic. In a drinking society like ours, where use of alcoholic beverages often benefits the individual or his social group behavior, even accepted social drinking has immediate and long-range risks. These include

drinking drivers, organic disease, psychiatric disorders and the development of alcoholism in one of every 15 persons who drink.[3]

Control of carriers is often an essential public health task. Epidemiologic study of any disease includes a search for possible carrier states and their accurate description. Studies are needed to show if the alcoholism sickness has any carriers who harbor the illness without symptoms but who can pass it on to others who have been free of the disease.

Just as this illness arises from "a complicated interplay of physiological, psychological and sociological factors"[4] so does its control depend on a complex interplay of individuals and agencies, with overlapping or conflicting policies and practices. The same government that directs its public health unit to control and treat chronic alcoholism may also license alcoholic beverage stores or operate its own. Tax monies collected from producers and vendors of alcoholic beverages support other government activities. Government is probably no more ambivalent, however, to its alcoholic citizens than is the medical profession or the general public.

Every physician whose practice could possibly include just one alcoholic should be concerned about the care of his patient whose chronic alcoholism is primary or complicates other diseases. Every physician who treats adolescents or adults should own "Manual on Alcoholism,"[4] an accurate, concise and well-written American Medical Association publication. All physicians should, in principle if not in fact, accept the chronic alcoholic as one who may need all forms of therapy in any medical facility of the community.

Finally—this really should be first—physicians have a responsibility to educate and caution the public against the danger of alcohol misuse. Effective disease control requires more than good treatment of current cases. New cases must be prevented by individual prophylaxis and by good public health practices—and alcoholism is our fourth largest public health problem.

As physicians and other health professionals prepare to receive skid-row and other alcoholics now confined to jails, and as public health authorities entreat hospitals to accept alcoholics as ill humans, one might ask from where will come the money to treat them. Health insurance plans now pay for short-term care in general hospitals and in some cases in psychiatric hospitals. Private funds, foundations or retirement plans will cover only a small portion of total expenses. Community public health must look to some form of government funding support, for so many of the identifiable chronic alcoholics are at least medically indigent. One need only to look at records of local public drunkenness jailings to sense the problem size, then to this add the unknown alcoholics who will be glad to use new and good resources. Faced with current shortages of money, personnel and facilities, any alcoholism program will begin with limited means and should expect little rapid improvement.

For the support of our purposes, the licensed beverage industries have an almost untouched reservoir of money, energy and goodwill which need not be viewed as entirely self-serving. "Alcoholism control," properly conducted, need not threaten their enterprise. The term should not be synonymous with nor lead to abolition or prohibition. Any reasonable discussion of control should include positive steps toward safety and improved use, as well as moves to limit the use of alcohol in possibly dangerous circumstances.

The licensed beverage industry has shown interest in the effects of its products on people. Like any other manufacturer, it must always consider possible toxic side effects of what it makes. Sooner or later, a producer is compelled by statute to assure customers that its products are safe. The licensed beverage industry should increase its support of moderate drinking habits, generously endow beds for the treatment of alcoholics in community hospitals, contribute to rehabilitation programs which now suffer from meager funding, and support research programs. Such "consumer service division" activities could have long-range beneficial effects on any drinking society.

Courts encompassing Maryland have handed over a sizeable responsibility for chronic alcoholics to the medical professions. Since physicians have repeatedly defined alcoholism as an illness, the community now expects the medical body to act promptly in an area it has claimed so successfully as its own.

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STATE OF MARYLAND
DEPARTMENT OF MENTAL HYGIENE

Isadore Tuerk, MD, Commissioner Kurt Gorwitz, ScD, Statistics Director

The Long-Term Patient

Half of all beds in Maryland's mental hospitals are occupied by patients who have been under continuous care in the same facility for five years or more. As shown in the following table, 64% of these 3,895 individuals were reported to be psychotic. Thirty-eight percent of the 1,420 non-psychotic were diagnosed as retarded, 14.4% have convulsive disorders, and 14.2% were reported to have diseases of the senium. Average (median) age at the time of admission was 32.5 years and is now 52.1 years.

AGE AT ADMISSION

Current Age and Diagnosis	Total	Less Than 25	25-44	45-64	65 and Over
TOTAL	3,895	905	1,981	762	247
Psychotic	2,475	552	1,430	428	65
Less Than 45	459	248	211	—	—
45-64	1,243	255	818	170	—
65 and Over	773	49	401	258	65
Nonpsychotic	1,420	353	551	334	182
Less Than 45	297	225	72	—	—
45-64	605	112	349	144	—
65 and Over	518	16	130	190	182

The reported median length of hospitalization of these patients is 19.6 years. Based on available expenditure figures for this period, this is equivalent to an average cost per person in excess of $25,000. That is, 100 million dollars has already been spent on the care and maintenance of this group. Currently, 6% of long-term patients are released each year with this discharge rate decreasing with increasing length of hospitalization. If this pattern remains unchanged, most of these individuals can be expected to remain hospitalized 15 to 20 more years until their ultimate death. On the basis of current cost trends, this represents an additional expenditure per patient exceeding $35,000.

The number of these long-term patients has declined by approximately 200 annually in recent years and is now at the lowest level. In 1960, for example, there were 5,016 such patients. Further continuing reduction in the size of this group can be anticipated since the number of patients becoming chronic in the hospital is now small. Efforts to accelerate this trend are dependent on the development and expansion of closely coordinated and centrally directed programs to:

- Counter symptoms and conditions leading to long-term hospital stay. (Many patients admitted for acute disturbances eventually become chronic and custodial unless continuing efforts are made to channel these individuals into a functioning, community setting.)
- Release and habilitate inpatients who have been hospitalized for extended periods. (Many of these could be discharged if adequate supportive community programs such as nursing homes, day and night centers and sheltered workshops were available in conjunction with continuing psychiatric services.)

HEART PAGE

Chris Papadopoulos, MD, Editor

A Service of the Heart Association of Maryland

In the presence of established coronary heart disease, successful correction of obesity may decrease the risk of sudden death and congestive heart failure and reduce blood pressure and serum lipid levels. Symptoms of angina pectoris may also diminish with weight reduction. Avoidance of cigarette smoking in subjects with established coronary disease is important to reduce both the risk of sudden death and recurrent myocardial infarction. An individually prescribed program of physical activity in recovered heart attack victims and in individuals with angina pectoris may improve their exercise tolerance and, especially, their psychological attitude.

Recommendations to Physicians Relative to Reducing the Risks of Coronary Heart Disease

In the long-term management of the coronary-prone patient it is advisable to recommend:

■ *Discontinuance of cigarette smoking.* (Cigar and pipe smoking have not been proven to be associated with any substantial increase in risk of coronary disease.)

■ *The avoidance of obesity or its correction if present.* Control of obesity should include not only reduced caloric intake but also participation in regular physical exercise.

■ *Development of a program of regular physical exercise.* A program of physical activity increases exercise tolerance and improves the psychological outlook of coronary-prone individuals. It may enhance the effect of a modified diet in controlling obesity, hyperlipemia, and the metabolism of carbohydrates. Physically active individuals tend to have a better prognosis when a heart attack does occur. It should be remembered that unusual, strenuous, physical exertion may precipitate a heart attack and should be avoided. Exertion that induces pain or dyspnea should be avoided. In general, unusual exercise shortly after a large meal, when experiencing emotional stress, or in extremely cold or hot weather should be discouraged.

■ *Modification of the diet.* Controversy continues concerning the particular items in the diet that are most basic to the artherosclerotic process. All agree, however, that overeating and weight gain are undesirable. An acceptable way to modify the usual diet, while maintaining sound nutrition, is to restrict the intake of saturated fat, cholesterol, and the simple sugars. Increasing the proportion of polyunsaturated to saturated fat is recommended. Such dietary changes, along with a suitable program of physical activity, may help in correcting obesity, reducing serum lipids, and improving carbohydrate tolerance. The individuals whose elevated lipid levels are primarily influenced by the intake of carbohydrates and/or simple sugars can only be identified by special studies including the clinical trial of a reduced carbohydrate intake.

From a statement released by the Central Committee for Medical and Community Program of the American Heart Association, December 8, 1967.

■ *Correction of elevated serum lipid levels.* According to present knowledge, lowering of serum lipid levels including beta and prebeta lipoprotein, triglyceride, and cholesterol is best accomplished by alteration in diet, correction of obesity, and a program of regular exercise. The use of various drugs and hormones to achieve normal lipid levels is under widespread investigation at this time. Subjects with familial lipid disorders, with a "milky" fasting serum (due to high serum triglycerides), serum cholesterol levels in excess of 400 mg%, or having xanthoma, should be investigated thoroughly, including determination of the several serum lipid components, the function of the thyroid gland, and the carbohydrate tolerance, as well as other procedures to identify disorders that require special management.

The interaction of blood pressure and lipid levels appears to be particularly important in the development of coronary atherosclerosis. Persons with both hypertension and hypercholesterolemia are at substantially increased risk and especially merit efforts to control both conditions. Here again, prophylactic measures applied in the preclinical phase should be more rewarding than those applied after the development of myocardial involvement.

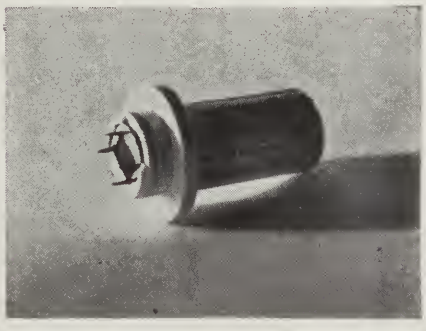
■ *Avoidance of situations which might precipitate acute coronary episodes.* Ischemia of the myocardium may be precipitated by intense emotional states, ingestion of an unusually large meal, unaccustomed strenuous exertion, and unusual exercise in very cold or very hot weather.

■ *Correction of disease states which may predispose to or may precipitate coronary heart disease.* It is recognized that anemia, hyperthyroidism, aortic valvular disease, pheochromocytoma, paroxysmal tachycardia, hypotensive episodes, hypoglycemia, certain drugs (epinephrine, hydralazine), and reactions to drugs may precipitate acute ischemic episodes.

Nutritional, hygienic and medical therapeutic measures are useful in the management of hypertension, diabetes, and gout. Pharmacological treatment is generally employed in these conditions when nutritional and hygienic measures are ineffective. Evidence indicates that even minor impairments associated with these diseases can have grave significance in individuals who are otherwise predisposed to coronary disease.

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BALTIMORE CITY HEALTH DEPARTMENT

Robert E. Farber, MD, MPH, Commissioner

A three-pronged attack is now underway in Baltimore City to reduce the high rate of illegitimacy among school-age girls—a rate which results in about 1,000 out-of-wedlock births a year in girls 16 years of age and under.

Preventing Teen Pregnancies

In 1967 the Baltimore City Public Schools instituted a new Family Life Education curriculum designed for use from kindergarten to grade twelve. This program of Family Life Education, now being implemented, represents the culmination of planning and experimentation in sex education—family living programs that have gone on for over a decade.

As early as 1956, Lillian B. Davis, ScD, then Supervisor of Health in the public schools, provided leadership and training in the area of sex education. Elective courses were instituted in several schools at the secondary level, and Parent Education Institutes were conducted for PTA's to help parents with problems of adolescence. According to the Curriculum Guide, the ultimate objective of Family Life Education is to help the individual achieve maximum physical, intellectual, emotional, social and spiritual growth in order to live harmoniously with members of his own and the opposite sex and to fulfill his role both as a person and as a dynamic force in the family life of his time. As noted in the Guide's introduction "Sex education, as part of Family Life Education, includes more than the facts of reproduction. Of greater importance is the development of attitudes toward the roles of sex and their psychological, social and economic implications."

A second and more community centered program, "Operation Save A Girl" is under the joint sponsorship of the Maryland League of Women's Clubs, the Baltimore City Health Department and the Monumental City Medical Society. A preliminary conference held January 27 focused on providing insights to the problem of teen-age pregnancies and served as a meeting ground for over 50 representatives of interested community agencies to begin the design of a plan to reduce such pregnancies. Conference speakers included Mayor D'Alesandro, Matthew Tayback, ScD, Deputy Commissioner of Health; Simon Messing, PhD, Cultural Anthropolgist, and Mrs. Vivian Washington, Principal of School No. 1 for pregnant girls. A panel discussion "Design for Prevention" completed the program. Private physicians, educators, and social welfare representatives aided in providing direction for this approach to preventing teen-age pregnancies.

Plans are now underway to develop an action program to reduce adolescent first pregnancies in a selected area of the city where childhood pregnancy has been increasing during past four or five years. The project will involve community leaders and other residents as well as utilize available community resources. A survey of sex and family planning knowledge of the area is being conducted by VISTA workers under the supervision of the City Health Department. This program seeks to develop new social institutions and reactivate existing social institutions to provide meaningful experi-

ences for girls 10 to 16 years of age so that they have outlets for their energies other than sexual outlets.

Radio Series

The third approach is being undertaken with the assistance of local radio stations. WEBB and WSID are presenting a continuing series of 15-minute programs each Sunday entitled "The Girl In Your Future." Aimed at the girl in school, the series presents personal interviews with inner city girls and young adults who have achieved a measure of success in life enabling the teen-ager to identify with members of her peer group. The program emphasizes the value of education, makes clear the dangers of early boy-girl sexual involvement and stresses the setting of attainable goals which are the stepping stones to economic and family security. The two weekly programs are supplemented by short, personalized spot messages prepared chiefly by inner city residents. "The Girl In Your Future" is broadcast over WEBB, 1360 on the dial, at 10:00 A.M. and on WSID, 1010, at 3:15 P.M. Interviews are conducted by Mrs. Margaret B. Pollard, Health Educator Consultant for Child Health Services. Supervision and production are by the Bureau of Health Information.

Profile of Teenage Pregnant Girl

Mrs. Vivian E. C. Washington, principal of the Edgar Allan Poe School No. 1 for pregnant girls, who is participating in both programs, has made some observations as a profile of the pregnant girl at her school. She has been interested in this problem for the past five years and has been principal of School No. 1 since 1966.

- The girl who becomes pregnant comes from all segments of our society.
- The pregnant adolescent girl represents a wide range in intelligence quotient—eg 63-130 at the Poe School (during 1966-'67).
- The girl is a very frightened girl. She has a poor self-concept, poor self-image and is usually ashamed and unhappy.
- The pregnant adolescent girl is a girl who may have had little opportunity for being successful in school. When given the opportunity and recognizing the fact that somebody does care, the girl becomes motivated to learn.
- The young lady begins to develop a positive self-concept once she feels she is valued, respected, and has an opportunity to be successful in her school work. We must trust her and allow her to assume responsibility.
- There is usually poor communication between the girl and her parents. This may be due to the fact that both parents are working and trying to improve the family circumstances. Most parents want to be good parents.
- The pregnant adolescent girl is usually emotionally insecure needing love and attention. Thus, many sometimes want a baby because they want someone to love.
- The adolescent girl faces a dilemma in morals. Teenagers are expected not to become involved in sexual activities; however, adult society through the mass media encourages such activities.
- The adolescent girl needs the kind of help that will help her become a positive contributing member of society.
- Leaders must respect these girls and must help them to respect themselves. The dignity and worth of every human being should be respected. This is particularly important for the pregnant adolescent girl.



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STATE OF MARYLAND DEPARTMENT OF HEALTH

William J. Peeples, MD, MPH, Commissioner

Concern for uniformity of diagnosis, treatment, and follow-up of phenylketonuria led to the formation in June 1966 of a 24-member *ad hoc* Advisory Committee on Hereditary and Metabolic Diseases, composed of leading pediatricians and biochemists from several hospitals and teaching centers in Maryland and the District of Columbia.

Recommendations Concerning PKU Diagnosis, Treatment and Follow-Up

A Subcommittee on Diagnosis, Treatment, and Follow-Up was established under the chairmanship of R. Rodney Howell, MD, The Johns Hopkins Hospital. Serving as members are: Samuel Bessman, MD, University of Maryland Hospital; Phillip Calcagno, MD, Georgetown University; Kurt Glaser, MD, Rosewood State Hospital; Wilson Grubb, MD, American Academy of Pediatrics; Neil Holtzman, MD, The Johns Hopkins Hospital; Wellington Hung, MD, George Washington University; and Benjamin D. White, MD, Maryland State Department of Health.

The subcommittee has formulated the following statement on phenylketonuria:

"This committee recommends that all infants who have a confirmed Guthrie test indicating a serum level of over 20 mgm % phenylalanine in the newborn period be hospitalized as promptly as is reasonable. The committee emphasizes that accurate confirmation of the diagnosis of phenylketonuria, which may require several days (but should be delayed no more than two weeks) is far preferable to a hasty and possibly incorrect decision to start a low phenylalanine diet. It is essential that hospitalization of such infants be done at facilities where determinations of serum phenylalanine as well as phenylalanine metabolites (such as phenylpyruvic acid, orthodroxyphenylacetic acid, etc.) are quickly available so that diagnosis and possible therapy can be quickly carried out. For practical purposes, this means that such patients should be hospitalized at The Johns Hopkins Hospital or its affiliated hospitals, the University of Maryland or its affiliated hospitals, the Sinai Hospital of Baltimore, or at Georgetown University or George Washington University and their affiliated hospitals in Washington, D. C.

"This committee further emphasizes that it is essential that phenylketonuria be diagnosed *not* on the basis of the Guthrie testing but on the basis of at least two quantitative serum phenylalanine determinations and that under no condition should the low phenylalanine diet be instituted *prior* to the availability of such quantitative serum data."

The committee further recommended that private physicians choosing to follow patients with hyperphenylalanemia in their own offices maintain "very close cooperation" with a laboratory experienced in the necessary determinations, in order that the data and their interpretation may be quickly obtained.

State law requires that all newborn infants (except when parents' religious beliefs contradict) receive the Guthrie screening test before reaching four weeks of age. Institutions where births occur are responsible for seeing that the test is performed; when birth occurs outside of an institution, the person filling out the birth certificate is assigned the responsibility. Laboratories are required to report positive results to the Maryland State Department of Health, which maintains a current registry of each confirmed new case of phenylketonuria. Materials and instructions for making the test may be obtained from the Department on written request.

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Contraindications: Comatose states or the presence of large amounts of C.N.S. depressants.

Precautions: Potentiation of C.N.S. depressants may occur (reduce dosage of such agents when used concomitantly). Use with caution in patients with chronic respiratory disorders. Antiemetic effect may mask overdosage of toxic drugs or obscure other conditions. Administer in pregnancy only when necessary. Because of possible drowsiness use cautiously and warn patients who operate vehicles or machinery.

Adverse Reactions: Drowsiness; dry mouth; nasal congestion; constipation; amenorrhea; miosis; mild fever; weight gain; hypotensive effects, sometimes severe with I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosages (in rare instances, may persist); lactation and moderate breast engorgement (in females on high dosages); and less frequently, cholestatic jaundice (use cautiously in patients with liver disease). Adverse reactions occurring rarely, include: mydriasis; agranulocytosis; skin pigmentation; epithelial keratopathy; lenticular and corneal deposits (after prolonged substantial doses).

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Are We Well Fed? Who Knows?

CORTEZ F. ENLOE, JR., MD
Editor, Nutrition Today

When one studies the descriptive titles of the grants now being made for research in nutrition and reflects on the nutritional problems faced by large segments of American society, it seems that something's out of kilter. There is a dissonance between what we could be doing with this time, talent and money and what is being done. We don't appear to be applying our material and intellectual resources as well as we might to solve the solvable nutrition problems that face too many children and adults and elderly and poor in our country. It's time to reexamine some of the goals of nutrition research in America.

There is so much talk these days about overpopulation and starvation elsewhere in the world that it is easy to lose sight of the fact all is not well right here at home. When it comes to setting priorities for our talents, we as "haves" are all too often made to feel guilty about the lot of the "have nots" by declaring that since we have such an abundance of food, there is little or no malnutrition in the United States. Every time a ship sails from an American port, laden with grain to fill the mouths of the hungry in some impoverished land, there is a little less inclination to accept the idea that there may very well be malnutrition within our own borders that we could do something about.

If we are honest with ourselves, we will admit there is at least the possibility that too many Americans are not well fed at all. Dr. William H. Stewart, the Surgeon General of the U. S. Public Health Service, in testifying before a Senate committee pointed out that while we had been able to conduct nutrition surveys all over the world, "We do not know the extent of malnutrition anywhere in the United States." Apparently, until recently, we have never been sufficiently motivated to carry out such studies in this country. Thankfully, the Secretary of Health, Education, and Welfare is now organizing a nutritional survey in certain poverty areas of the United States that may throw some light on this dimly lit subject. This is a step in the right direction and it deserves the widest support.

Frederick J. Stare of Harvard, who has done as much as anyone in America to awaken the public to the need for good nutrition, has written repeatedly and lectured from one end of the country to the other on the importance of the implantation of preference for good food in the earliest possible moment of childhood, but just how much preference has thus been implanted? Who knows?

Talk to any grade-school teacher or a perceptive school nurse. Ask them about the number of pretty little six-, seven- and eight-year-olds who trudge to school each morning without breakfast. You will certainly be alarmed at the answer you get. Here is a budding nutrition problem that borders on the scandalous. What is the meaning of this lack of what nearly everyone regards as the most essential meal of the day for these little children who are still growing and who are struggling to learn? What does this do to their ability to learn? What does it do to their present and future health? What can be done about it? Who knows?

One of the best organized studies on the nutritional status of our teenagers has now expired at midpoint, starved from the lack of the two vital foods: motivation and money. Yet what is the nutritional status of our young people? We know that they are undergoing the most stressful period of their lives. We know their food demands are tremendous, and we know they develop all sorts of faulty eating habits. How well nourished are these young children in America? They look healthy. So do the Watusi. But, are our youngsters indeed well nourished? Who knows?

Middle-age obesity is said to be the major illness in our land today. That the clinicians who see obese patients need the help of the nutritionist is evident from the fact that the practicing physicians' record in trying to get a firm grasp on this nettle is less than enviable. Because clinicians don't seem to be able to cope with obesity and it has not been given the attention in research that a national

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disease deserves, the quacks and the charlatans have moved in. What can be done about obesity? Who knows?

A little over a year ago, the American people made a commitment to pay for the medical care of our elderly citizens. This is a very large and costly undertaking. Anything that can be done to improve the health of the older people is not only a moral obligation but economically wise. It is, therefore, surprising to find that the list of grants for research this year reveals little curiosity about the nutritional problems of the elderly. Is there anything we know about nutrition that would return some of them to productivity and brighten their remaining years? Who knows?

It is generally accepted that poverty and undernourishment are bedfellows. The economists know where to find the poverty, but can we spot the undernourishment? Considering this parallel, malnutrition is undoubtedly prevalent in Appalachia, in our slums and in certain rural areas. It's not hard to imagine that there are enough interesting problems in these places to whet the intellectual appetites of a small army of nutritionists. But is anybody shipping "Incaparina" to Harlem? What is the effect of this undernourishment on these people, on our economy, on our society? Is it this that freezes them into the hard core of unemployables that so vexes our social planners? To what extent is nutritional status to blame for the predicament of the poor, seemingly uneducable Negro whose plight in this land of plenty is offensive to Christian decency? Who knows?

The time has come when we as physicians, dietitians and nutritionists—scientists all—must ask ourselves whether the people of America are really well fed. We are the only ones who can know. It's time we looked homeward. It's time we found out.

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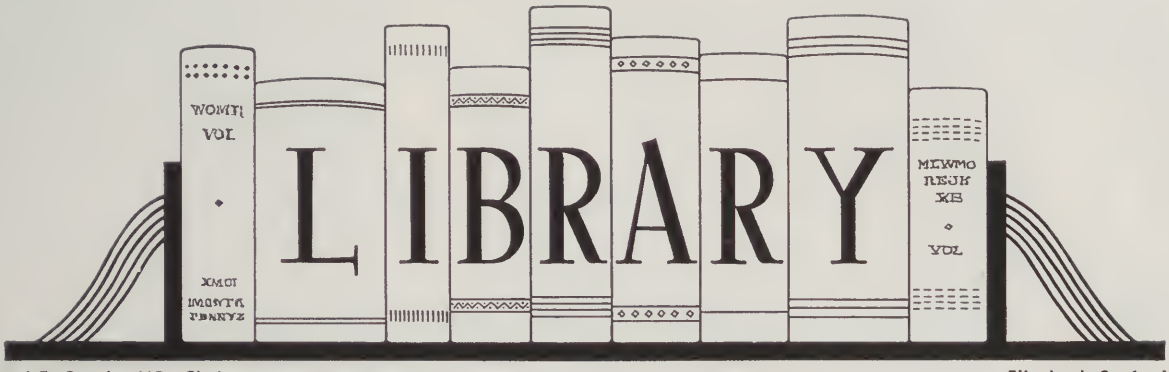


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Paul F. Guerin, MD, Chairman
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Archer Manuscript Discovered

One of the finds recently located in the collection of the library was a history of the Harford County Medical Society in the handwriting of James Archer. This constitutes a significant discovery in our efforts to collect all possible historical material concerning the component societies of the state and establishing a definitive and original history of Maryland medicine at its sources. It also adds a valuable record to the collection of Archer manuscripts.

Another interesting and very amusing piece discovered in the basement of the building were the minutes, in longhand, of the Bacillus Club, which apparently had some gay and relaxing hours of fellowship. Needless to say, these were not minutes of professional or scientific meetings.

At the last meeting of the Library Committee Mr. Lee Ash met with the members, showed them a few of the important items we have been unearthing, some cataloged and some unprocessed, and recommended future steps to be implemented. Afterward the committee took a 'guided tour' of the library quarters in order to see the magnitude of the job that lies ahead.

New Accessions

BOOKS

(Arranged by author and title)

Ref.
Z 1000
A5
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RC 313 .A6 M2 1967	**Maryland. Governor's Committee on Tuberculosis Control.** Report. Baltimore. 1967.
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RC 182.R4 T3 1967	**Taran, Leo M:** Collected works on rheumatic fever. International Professional Publications, Inc. Flushing, N.Y. 1967.
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HA 203 U6 1965	**U.S. Division of Vital Statistics.** Vital statistics of the United States. 1965. Washington. U.S. Government Printing Office.
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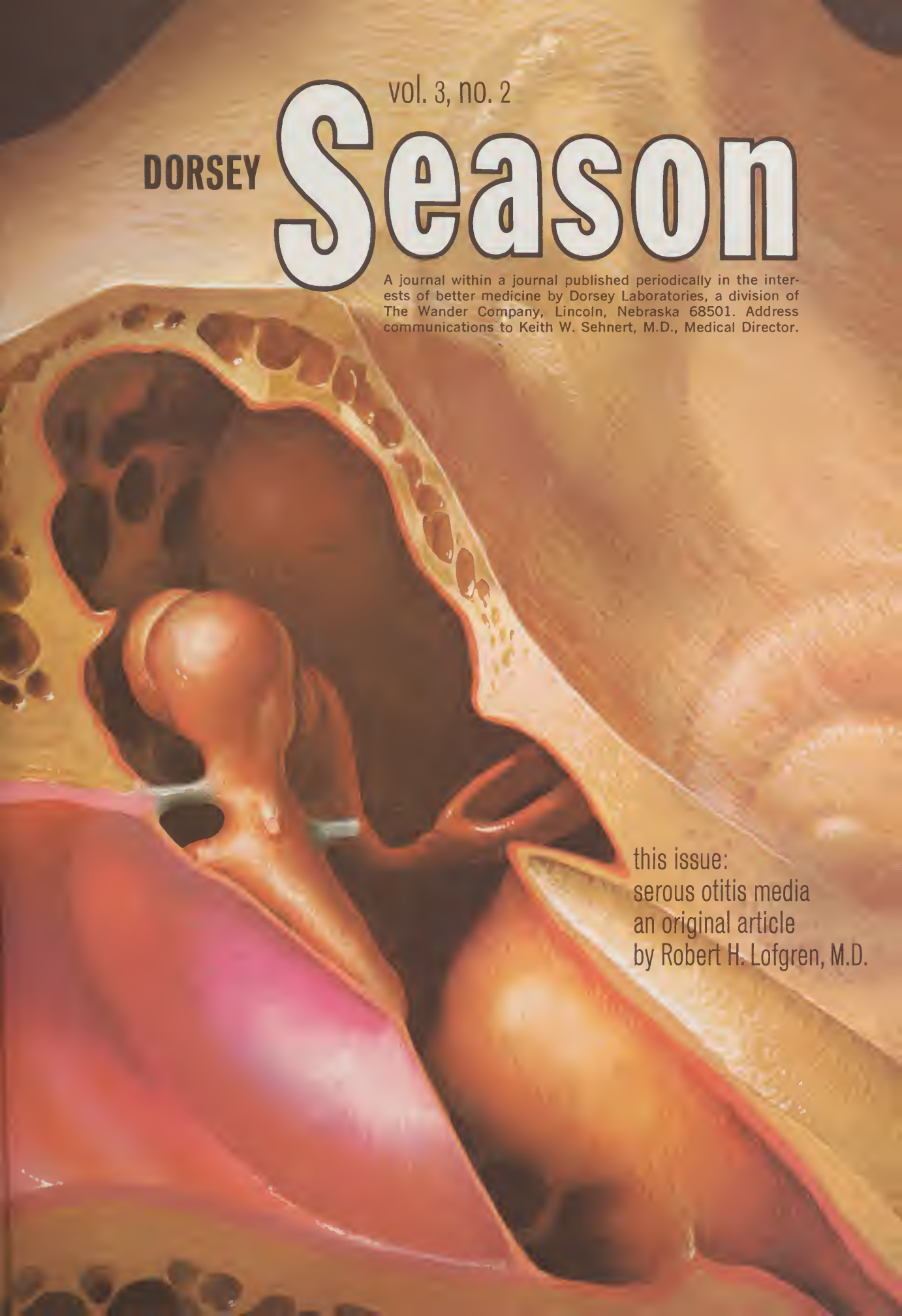
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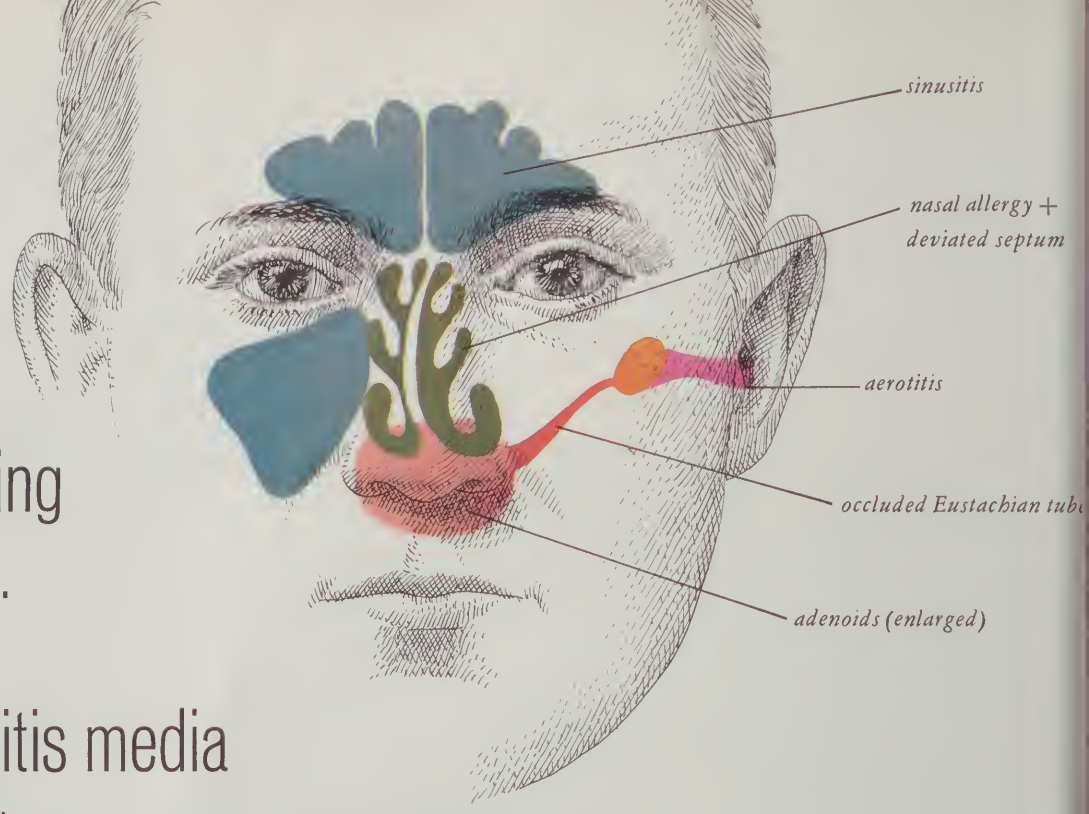
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this issue:
serous otitis media
an original article
by Robert H. Lofgren, M.D.



the complaining earache... key to serous otitis media

Robert H. Lofgren, M.D.
Associate Surgeon, Massachusetts Eye and Ear Infirmary, Boston, Massachusetts

Serous otitis media is probably the most common ear problem in children, especially in the wintertime. Diagnosis is usually easy in adults, but may be quite difficult in children, especially the very young child where one has to depend almost entirely on the physical findings.

The symptoms of serous otitis are a fullness in the ear, a mild hearing loss and mild earache. The earache can best be described as a "complaining earache" instead of a "screaming earache" as found in purulent otitis media. A young child may be irritable and pull at the ear. In milder cases, and as the ear recovers, gurgling and popping noises can be heard in the ear.

On examination one may see a yellow tympanic membrane and if a fluid level is present the diagnosis becomes easy. However, the eardrum may be dull gray, or slightly pink, or even perfectly normal. Pneumomassage using a Siegle otoscope or a closed-head electric otoscope must be done on both ears, otherwise the diagnosis will be frequently missed. Attempted movement of the drum with the pneumatic otoscope produces either a sluggish motion of the drum or no motion at all instead of the easily movable normal drum. The Rinne test is negative and there is a 15-20 decibel conductive hearing loss. The bone conduction may be better than normal and an air-bone gap may exist even with the air conduction within normal limits. Occasionally one finds a false nerve deafness on the audiogram when thick glue-like fluid causes immobility of both the oval and round window. Both conditions return to normal when the fluid is removed, but they make the interpretation of screening audiograms very difficult.

There is no single cause for serous otitis. One factor always present is blockage of the eustachian tube, but this alone is not enough to produce fluid. There must also be an inflammatory reaction. Blockage of the eustachian tube may be caused by many conditions. In children the most common cause is enlarged adenoids. In the summer the next most common cause is allergy. Upper respiratory infections or influenza are common causes in the winter. Nasal allergy, acute and chronic sinusitis, nasal septal deformity and cleft palate can all cause eustachian tube obstruction. Some children may have a congenitally small eustachian tube, but fortunately they usually "grow out of the problem."

The first sign of a nasopharyngeal tumor is often a serous otitis. One must always rule this out in any adult who later in life develops repeated or persisting serous otitis. Causes sometimes overlooked are nasogastric tubes after surgery, simple obesity and cardiorenal disease, which may produce congestion in the mucosal lining of the eustachian tube. In recent years we have been seeing a new cause—acute otitis media, where the patient is adequately treated with antibiotics but where drainage has not been

established either through the eardrum or down the eustachian tube. A sterile exudate is left in the middle ear.

The inflammatory response may be caused by a marked negative pressure as in air otitis from flying, or it may be from a mild bacterial or viral infection in the middle ear. Serous fluid is a good culture medium and will frequently go on to purulent otitis media, especially if the original blockage was caused by an infectious process such as acute rhinitis or adenoiditis. When the infection heals there may be scarring in the middle ear mucosa. Mucous glands develop in this tissue and pour out a thick mucoid material. This ear usually looks normal until a pneumatic otoscope is used. The objectives in treating serous otitis are to remove the obstructing agent and to provide drainage from the middle ear. Often this can be accomplished by decongestants and nose drops. If large obstructing adenoids are present they should be removed. Sinusitis should be treated with oral decongestants or nose drops, plus antibiotics where indicated. Nasopharyngeal tumors should be treated. Allergies should be treated with antihistamines and, where indicated, by desensitization.

If the fluid does not clear with medical treatment within a week or two, a myringotomy should be done. If there is a question of active infection or if the fluid looks purulent, as is seen at the conclusion of acute otitis, cultures are taken. On adults this can be done in the office without anesthesia. It is no more painful than an intravenous needle for a blood test. A good safe topical anesthetic has a tremendous psychological value to the patient. Children under the age of 1 require no anesthesia. Between the ages of 1 and 3 anesthesia is not absolutely essential although a general anesthetic may be used to avoid the child's possible mistrust at follow-up examinations. I usually do the myringotomy at the same time as the adenoidectomy if the adenoids are enlarged. Once drainage has been established with decongestants or by myringotomy, positive pressure inflation of the middle ear is invaluable in forcing out the serous fluid and keeping it from reforming. The patient can do this himself by performing the Valsalva maneuver. This should be done several times a day, by taking a deep breath, holding the nose and blowing hard against the closed lips for a second or two.

In resistant cases where the fluid reforms as soon as the myringotomy heals, small polyethylene tubes are inserted through the myringotomy site. Insertion of the tubes, even in adults, usually requires an anesthetic. Good anesthesia can be obtained by infiltrating the canal wall with a local anesthetic, using a #27 needle. Once inserted the patient has no sensation of the tubes' presence. Be careful to caution the patient or parents not to allow any water to get into the ear canal while a myringotomy is open or a tube is in place. Water can be kept out by a pledget of lamb's wool in the ear canal or a cotton pledget thickly coated on the outside with petroleum jelly. I check these patients a week after a myringotomy to be sure it is healed and at two month intervals until the tubes have fallen out, usually within three to six months after insertion.

The mucoid type of fluid is so thick and tenacious that it is appropriately called a glue ear. It is aspirated only with difficulty through the eardrum, and occasionally must be removed through a tympanotomy. This thick, glue-like fluid is prone to recur, as the myringotomy usually heals long before the mucous membrane has returned to normal. Repeated myringotomies, as many as ten or twenty, were formerly required for this condition. Now polyethylene tubes are inserted initially when this thick, glue-like material is found. At times a subacute mastoiditis may accompany the serous otitis, which will necessitate a simple mastoidectomy before the condition can be eradicated. Usually the thin serous fluid readily responds to decongestants or to a myringotomy and removal of the eustachian tube obstruction. Occasionally, however, even serous fluid will repeatedly reform. For this, resection of the tympanic plexus of nerves which lies on the promontory of the middle ear has been carried out, as the tympanic branch of the glossopharyngeal nerve is the secretomotor nerve to the ear.

Failure to diagnose serous otitis is the most common cause of the recurrent, almost continuous otitis me-

Otoscopic Views



Normal



Acute Serous



Acute Purulent



Chronic Serous

dia seen in young children. In these cases a myringotomy will frequently provide a long-term cure without adenoidectomy or any other surgery. Failure to do this may allow the condition to go on to acute or subacute mastoiditis. Adhesive otitis media with scar tissue binding down the ossicles or tympanosclerosis may also result with permanent impairment of hearing. The prognosis for hearing with adhesive otitis or tympanosclerosis is usually poor. If the adhesions are removed, they reform, and the same is frequently true of tympanosclerosis even after a tympanoplasty. For many of these people a hearing aid is the only solution. The constant negative pressure in long standing serous otitis media may draw in either Schrapnell's membrane or the posterior superior portion of the eardrum forming a pocket to cause a chronic otitis media with cholesteatoma, which may not become apparent until twenty or thirty years later.

The non-medical complications of improper diagnosis or treatment may be even more serious. The irritable child, the frequent bouts of acute purulent otitis media with pain and fever, the expense of antibiotics and doctors, and the time lost from school or work affect the entire family.

In summary, serous otitis has many causes. There is a blocking of the eustachian tube and an inflammatory reaction in the middle ear mucosa, the latter usually caused by a mild infection. The treatment is to provide immediate drainage by decongestants and where necessary, by a myringotomy. The obstructing agent must be removed by surgery if it is adenoid or by oral decongestants, and antihistamines or nasal spray if it is an upper respiratory infection or allergy. Occasionally resistant cases require plastic tubes placed through the eardrum or other more radical surgery. Failure to treat properly leads to hearing loss which may be permanent, repeated acute otitis media or possibly even chronic otitis media with cholesteatoma.

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AAP Cautions Against Unnecessary Public Warnings for Vaccines

The American Academy of Pediatrics has cautioned against "undue emphasis" in requiring public warnings regarding isolated complications or hazards which might result from use of vaccines in mass immunization programs.

Such warnings, the Academy pointed out, "would adversely affect the health of the public by unwarrantably diminishing participation in these programs."

The AAP Executive Board, meeting in Atlanta during the organization's spring session at the Regency Hyatt House, expressed its concern over a recent court decision imposing liability on a drug manufacturer for not warning the public participating in a mass immunization program about remote risks involved in receiving oral poliovirus vaccine.

The Board strongly endorsed recommendations set forth by the Academy's Committee on Control of Infectious Diseases concerning the recent two-to-one decision of the United States Court of Appeals for the Ninth Circuit in the case of Davis vs. Wyeth Laboratories, Inc., Jan. 22, 1968.

Emphasizing the possible implications of this decision upon important public health programs, the Academy, in its statement, pointed to several types of immunization programs that would be affected by the court decision, including those currently administered by schools, public health departments, community health programs such as Head Start, and others.

"The decision may have deleterious effects both on the conduct of, and public participation in, efforts directed against many other infectious diseases such as measles, diphtheria, whooping cough, tetanus, and others," the AAP's statement cautioned. "In the opinion of the AAP Committee on Control of Infectious Diseases, the benefits of these programs are tremendous."





Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of Tofrānil and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before Tofrānil may be substituted. Initial Tofrānil dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, Tofrānil should not be used during the first trimester of pregnancy.
Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment with Tofrānil. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy.
Because of its anticholinergic effect, caution should be observed in prescribing Tofrānil for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when Tofrānil was added to the regimen.
Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 years of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (includ-

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The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated.

In patients with cardiovascular disease, hyperthyroidism or increased intraocular pressure; or in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication, or antihypertensive adrenergic neuron-blocking agents; and in those in their first trimester of pregnancy, the special precautions listed in the prescribing information should be carefully observed.

Toxic reactions severe enough to require discontinuation of Tofrānil are uncommon. However, for complete details, please refer to the full prescribing information.

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ng hypomanic and manic episodes) which may require dosage reduction nd/or addition of a tranquilizer or emporary discontinuation of the drug, pileptiform seizures, orthostatic ypotension and substantial blood ressure fall in hypertensive patients, urpura, transient jaundice, bone marow depression including agranulocysis, sensitization and skin rash ncluding photosensitization, eosinohilia, and mild withdrawal symptoms n sudden discontinuation after prolonged treatment with high doses. ccasional hormonal effects (impotence, decreased libido, and estroenic effects) may be observed. tropine-like effects may be more ronounced (e.g. paralytic ileus) in isceptible patients and in those sing anticholinergic agents (including antiparkinsonism drugs). *utpatient Adult Dosage:* Initially, mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.

Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.

A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.

Availability: Tofrānil: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.

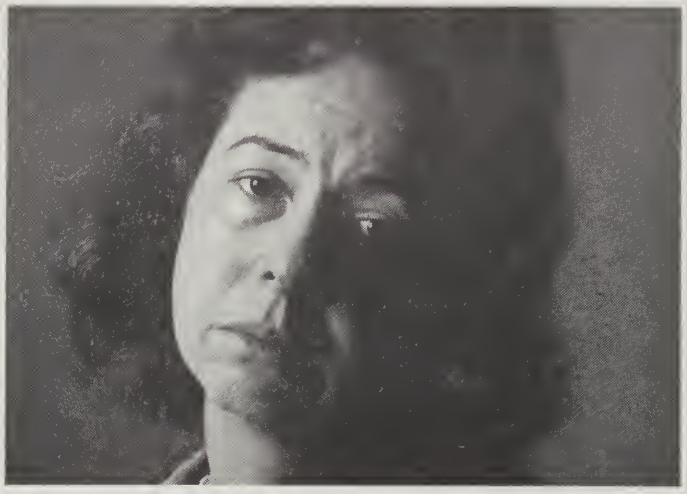
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Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In bacterial/allergic u.r.i., ACHROCIDIN brings the treatment together in a single prescription —prompt relief of headache and congestion together with effective control of the tetracycline-sensitive organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals.
Contraindications: History of hypersensitivity to any component.
Warning: If renal impairment exists, even usual doses may lead to liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Hypersensitive individuals may develop a photodynamic reaction to natural or artificial sunlight during use. Individuals with a history of photosensitivity reactions should avoid direct exposure while under treatment, which should be discontinued at first evidence of skin discomfort.
Precautions: Some individuals may experience drowsiness, anorexia, and slight gastric distress. If excessive drowsiness occurs, it may be necessary to increase the interval between doses. Persons on full dosage should not operate any vehicle. Use may result in overgrowth of nonsusceptible organisms. If infections appear during therapy, appropriate measures should be taken. Infections caused by beta-hemolytic streptococci should be treated for at least 10 full days to help prevent rheumatic fever or acute glomerulonephritis. Use of tetracycline during tooth development may cause discoloration of teeth.
Adverse Reactions: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity; onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels following full therapeutic dosage has been reported. This has disappeared rapidly when drug was discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy and in children given the drug during the neonatal period, infancy, and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Lederle

327-8

WOMAN'S AUXILIARY

Mrs. Harry L. Berman, Editor

AMA Auxiliary to Hold 45th Annual Convention

Conducted tours through a unique rehabilitation mobile unit and an afternoon of continuous health education films will be new features at the 45th Annual Convention of the Woman's Auxiliary to the American Medical Association. Headquarters for the June 16-20 meeting will be the St. Francis Hotel, San Francisco, Calif.

Highlighting the four-day session will be the new mobile demonstration unit called "Homemaking Unlimited." This five-ton coach, sponsored by the School of Home Economics of the University of Nebraska, shows handicapped housewives how they can be self-reliant homemakers despite physical limitations. During the convention the unit will be displayed on Powell St., across from the St. Francis Hotel.

On Sunday, June 16, the Auxiliary will hold a reception for the president, Mrs. Karl F. Ritter, Lima, Ohio, and president-elect, Mrs. C. C. Long, Ozark, Ark., from 5 to 7 P.M.

The convention will formally open at 9 A.M., Monday, June 17. Mr. Philip Lesly, president of The Philip Lesly Co., a Chicago-based public relations firm, and counsel on PR and communications to the AMA, will deliver the keynote address.

The Monday luncheon will honor the leaders of women's volunteer organizations throughout the United States. Featured speaker will be Henrik L. Blum, MD, Clinical Professor of Community Health Planning, University of California School of Public Health. Dr. Blum will discuss "Program Planning and Implementation."

Milford O. Rouse, MD, AMA President, will be the guest speaker at the Tuesday, June 18, luncheon honoring national Auxiliary past presidents and AMA Officers, Trustees and wives. At this time Mrs. Ritter will present the Auxiliary's contribution to the American Medical Association Education and Research Foundation. Last year's gift totaled $384,649.

The Tuesday afternoon meeting will feature a program by the Communications Committee relating to state publications. Following this program, films, including several on sex education, drug abuse, physical fitness and nutrition, will be shown for the remainder of the afternoon. This new feature will provide Auxiliary members with a catalog of available health education materials to be used in conjunction with existing Auxiliary programs.

The post-convention conference, usually scheduled for Thursday morning, will be held on Wednesday afternoon to give Auxiliary members free time on Thursday to visit areas of San Francisco. The Board of Directors will meet Thursday morning, instead of Wednesday afternoon.

The Auxiliary will also sponsor a program of daily activities for the pre-teens and teenagers of Auxiliary members and guests. Lunch in Chinatown and a cable car ride are among the events being considered.

Local arrangements for the convention are under the direction of Mrs. Lloyd Gillin and Mrs. Don C. Musser, both of San Francisco. Mrs. Ralph B. Eusden of Long Beach, Past President of the Auxiliary, is honorary chairman.

A more detailed listing of events is as follows:

Friday, June 14

Finance and Communications Committees meetings, 9:00 A.M. Joint meeting with Program Development Committee, 1:00 P.M.

Saturday, June 15

Meeting of the Board of Directors, 9:00 A.M.-5:00 P.M. National chairmen and National representatives to meetings (auxiliary and others) are invited to attend the afternoon meeting to give brief reports.

Board of Directors Luncheon, 1:00 P.M. Guests will be National Board, National Chairmen, Past Presidents and Honorary members.

Sunday, June 16

Meeting of the President-elect, Mrs. C. C. Long, with the 1968-69 Chairmen, 9:00 A.M. Bylaws Committee meeting, 8:00 A.M. Resolutions Committee meeting, 10:00 A.M. Registration will open at 11:00 A.M. Hospitality Room will open at 11:00 A.M. Coffee will be served until 1:00 P.M. Reception, honoring the National President and President-elect, will be held from five to seven o'clock at the St. Francis Hotel. "Dutch treat" bar with hors d'oeuvres courtesy of National Auxiliary. Members, husbands and guests cordially invited. Members are requested not to include family under twenty-one years of age.

Opening Meeting of the AMA House of Delegates. (Consult AMA program for time and place.)

AMA Medicine and Religion Program, 8:15 P.M., California Masonic Memorial Temple. Program enclosed.

Monday, June 17

Formal opening of the convention, 9:00 A.M. Business meeting 9:15 A.M. to 12:15 P.M. and 2:30 P.M. to 4:30 P.M.

Guest Day Luncheon for leaders of National Women's Volunteer Organizations, Auxiliary members and guests, 12:30 P.M., Mural-California Room. Guest speaker: Dr. Henrik L. Blum, Clinical Professor of Community Health Planning, University of California.

The afternoon program will schedule part of the state reports under the direction of the National Vice Presidents; remainder on Tuesday morning.

NOTE: Nominations for the 1969 nominating committee will be made during the business meeting Monday morning. The election will take place Tuesday afternoon in a polling place so designated. The hours for casting ballots will be from 2:30 P.M. to 6:00 P.M.

With this procedure it will be absolutely necessary and essential that state auxiliaries make certain all delegates are supplied with the proper credentials.

Ballots will be distributed ONLY to delegates with official credentials. Complete details will be sent to the state presidents at a later date. This is to alert them to the procedure and the importance of handling credential cards as required when they are received.

Tuesday, June 18

Presentation of state reports (continued from Monday).

Annual luncheon, honoring National Past Presidents. Guest speaker: Milford O. Rouse, MD, President, American Medical Association.

COMMUNICATIONS PROGRAM—2:00 P.M. to 2:30 P.M.

The Communications Committee will present a program with emphasis on "How to get the most out of your State Newsletter" and suggestions to state presidents, presidents-elect and state editors on the value of the newsletter in public relations activities.

From 2:30 P.M. to 4:30 P.M., there will be a presentation of health education films available through AMA Film Library and other sources for use by county and state auxiliaries.

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Wednesday, June 19

General Meeting—9:00 A.M. to Noon
Amendments, resolutions, reports and installation of the new officers will follow. Board of Directors luncheon and meeting 12:15 P.M., with 1968-69 Chairmen.

Postconvention Conference for Presidents and Presidents-elect (open to all Auxiliary members), 2:30 P.M.

Presentation and discussion of 1968-69 programs and projects.

AMA Round-Up—Ernest B. Howard, MD, Asst. Exec. Vice President, American Medical Association.

Thursday, June 20

Meeting of the Board of Directors, 9:00 A.M. Leadership Conference for Workshop Leaders, 1:00 P.M.

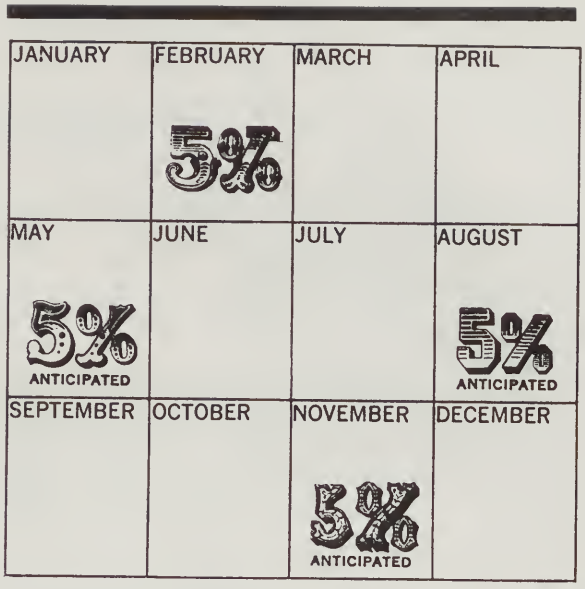
The state presidential delegate is the president in office at the time of the National convention, or the president-elect, or in the absence of both, an official representative appointed by the state auxiliary. No alternate is allowed.

Report, limited to three minutes, shall be read by the state president, or the immediate past president if she has prepared the report; unless permission of the convention is given another delegate from that constituency.

Chairman of delegates is appointed by the President in office at time of national convention and and can be any member of the delegate body.

TEEN-AGE PROGRAM: A program for Preteens and Teen-agers of Auxiliary members is being planned by the Teen-age Committee in San Francisco.





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Each capsule contains:

Vitamin B_1 (as Thiamine Mononitrate)	10 mg
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Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
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Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100.

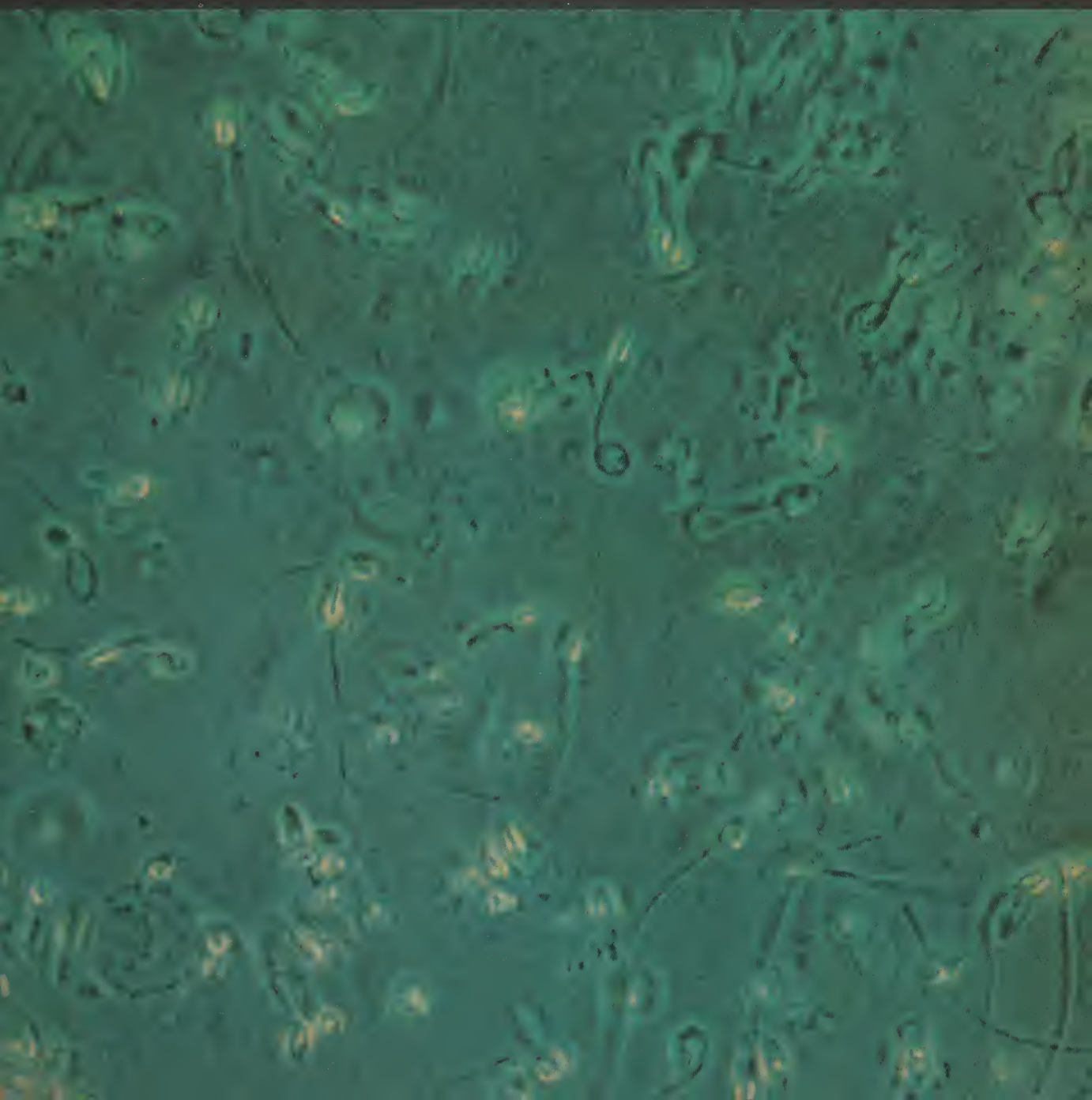
LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, N.Y.

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When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. c̄ mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of NORINYL-1 (norethindrone 1 mg. with mestranol 0.05 mg.) in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with NORINYL-1. Therefore, if such tests are abnormal in a patient taking NORINYL-1 it is recommended that they be repeated after the drug has been withdrawn for two months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibromyomata may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. 5. NORINYL-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, and as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged NORINYL-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving NORINYL-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. 11. Because of the effects of estrogens on epiphyseal closure, NORINYL-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with NORINYL-1 may mask the onset of the climacteric. 13. The pathologist should be advised of NORINYL-1 therapy when relevant specimens are submitted.

Side effects observed in patients receiving oral contraceptives: The following adverse reactions have been observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretion, suppression of lactation when given immediately postpartum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression.

Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching.

The following occurrences have been observed in users of oral contraceptives (a cause and effect relationship has been neither established nor disproved): thrombophlebitis, pulmonary embolism, neuro-ocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, Factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from

SYNTEX

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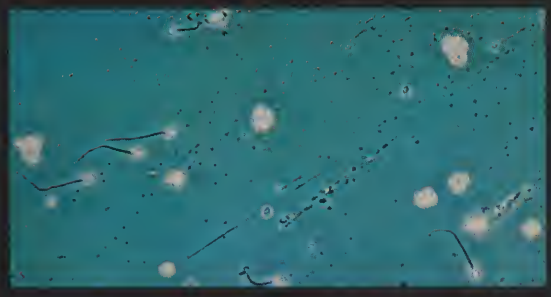
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

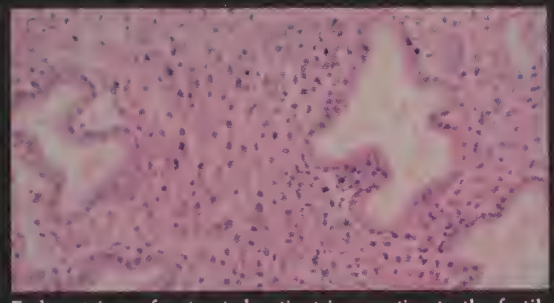
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.



Spermatozoa appear healthy, active, freemoving.

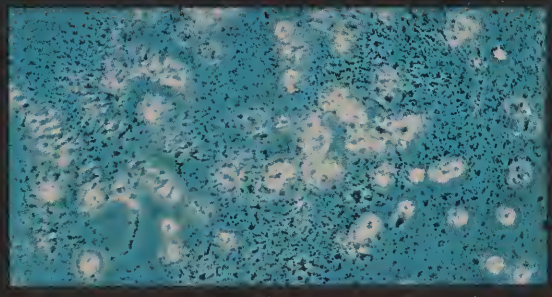


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

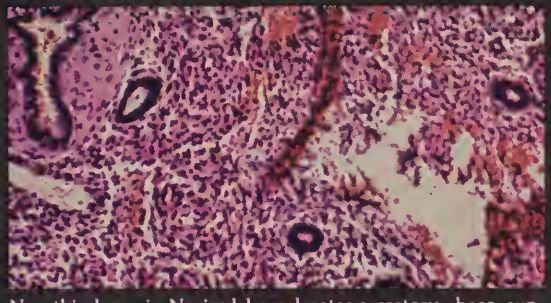
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

Norinyl®-1 tablets
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- new low dose of time-proved ingredients
- established norethindrone/mestranol ratio
- lower patient cost



Indications: Hypertension and many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.
Use with caution in pregnant patients, since the drug may cross the placental barrier and adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.
Precautions: Antihypertensive therapy with Hygroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Hygroton should be discontinued and potassium supplements given, provided the



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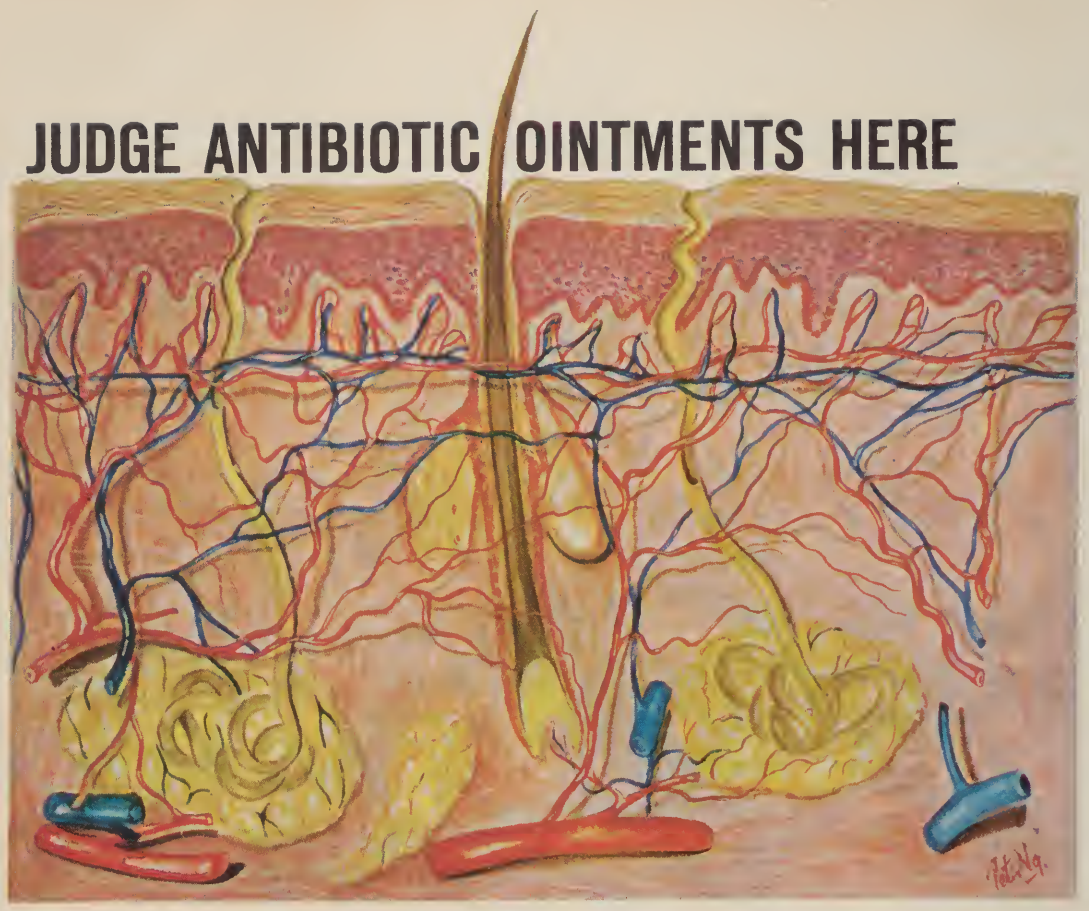
Hygroton therapy may mean troublesome side effects for some patients. And you can't prescribe it for patients with hypersensitivity to the drug or severe renal or hepatic diseases. Before writing it for your patients, please check the prescribing information. It's summarized below.

tient does not have marked oli-
ria.
ke special care in cirrhosis or
vere ischemic heart disease and
patients receiving corticoste-
ids, ACTH, or digitalis. Salt re-
riction is not recommended.
iverse Reactions: Nausea, gastric
itation, vomiting, anorexia, con-
pation and cramping, dizziness,
eakness, restlessness, hyperglyc-
mia, hyperuricemia, headache,
uscle cramps, orthostatic hypo-
tension, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.
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Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

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- Americans covered by private health insurance as of December 31, 1967 include an estimated 150 million for surgical expense and 121 million for medical expense insurance.

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New Pamphlet on "the Pill"

Many of the questions patients ask about "the pill" and other birth control techniques are answered in a AMA pamphlet, "Contraceptive Drugs & Devices."

Containing the latest available facts on contraceptive drugs and devices, the publication replaces the former AMA pamphlet, "Is the Pill the Answer?"

The six-page pamphlet discusses the various types of oral contraceptives and intrauterine contraceptive devices, their effectiveness and the incidental effects which may occur with their use. It urges readers to obtain their physician's advice in selecting a contraceptive method that suits their individual needs and desires.

Review copies may be obtained from the AMA's Health Education Department. Quantity orders may be obtained from the Order Department at prices ranging from 14¢ each for 50-99 copies to 8¢ each for 1,000 or more.

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Sizes 34 to 46

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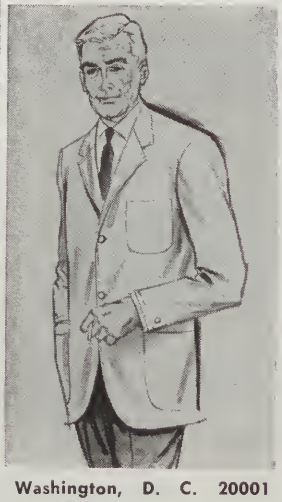
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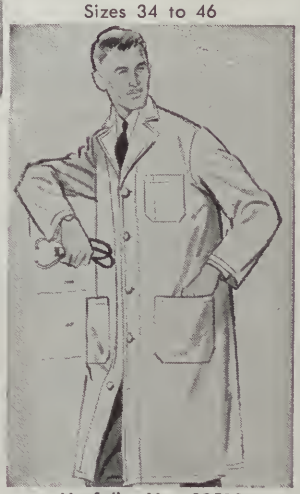
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Doctor Ackerman Predicts 'Usual and Customary' Increase

Carl R. Ackerman, MD, chairman of the board, National Association of Blue Shield Plans, foresees an acceleration of the trend toward usual and customary fee programs by Blue Shield Plans "over the next two to three years."

Interviewed in the January 8, 1968 issue of *Medical Economics,* Dr. Ackerman observed:

"The move to usual and customary is approaching a crescendo, and by 1970 all the Plans will probably offer such coverage. Just look at its development recently: Out of a total of 73 U. S. Plans, the number offering some form of usual and customary coverage has exploded from a handful in 1965 to 48 today."

When asked to explain Blue Shield's move toward this type of fee program in contrast to the commercial carriers which have incorporated usual-and-customary-type payments in their major medical programs for 20 years, Dr. Ackerman replied:

"Twenty years ago I would have considered paid-in-full benefits for all subscribers an abdication of the responsibility of Blue Shield and the medical profession to assure low-income subscribers of adequate protection against high health costs."

With the enactment of Medicare and Medicaid, however, government "has assumed the responsibility once borne by the medical profession through Blue Shield," he said.

"Today the public and the medical profession both want a 'fair fee' to coincide with a 'paid-in full fee.' That's why the usual and customary approach is so satisfying to the two parties in which Blue Shield is most interested—the patient and the doctor," Dr. Ackerman explained.

In response to a question concerning possible fee curbs inherent in the fee profiles developed by Blue Shield Plans, Dr. Ackerman pointed out that he knew of no usual and customary formula "that doesn't have a built-in mechanism to adjust fees to keep in step with inflation or to reflect the individual physician's increasing prominence and ability."

Neither does it mean, however, "that 'the sky's the limit' will be acceptable," he added.

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Personal Communication with Teen-agers May Help Solve the Problem of Drug Abuse

"More teen-agers would resist the temptation to join a 'pot party' if they were given the facts about the potential dangers of drug abuse," states David Blake, PhD, assistant professor of pharmacology at the University of Maryland School of Pharmacy.

Dr. Blake has involved himself in a project to visit area high schools and talk to students directly in order to explain these dangers. Thirteen students from the pharmacy school volunteered to accompany him. After Dr. Blake presents a lecture and films to the students, the volunteers meet with small groups of students for informal discussion.

"We feel that students are given piecemeal information by the press, movies, and friends. What they really want and need is objective information," Dr. Blake emphasized. "And since high school students naturally respond best to authorities near their own age, I'm very pleased that so many pharmacy students are interested in talking with them.

"Because of his education and professional responsibility in community health, the pharmacist is in a unique position to inform the public about drugs," Dr. Blake says. "And teen-agers are the group most susceptible to drug addiction—they are the ones we should concentrate on reaching."

An indication that Dr. Blake is reaching the teen-ager is this comment from a Dulaney student, following the presentation there:

"This is the first time we have been presented with this depth of information. Sure, you can read about it [drugs] in books, but we are not talked to frankly about it. . . . More presentations like this one are needed in more high schools all over."



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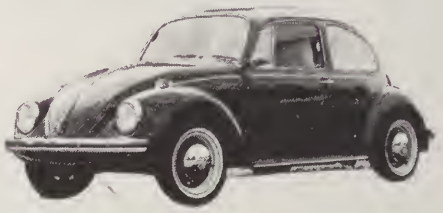
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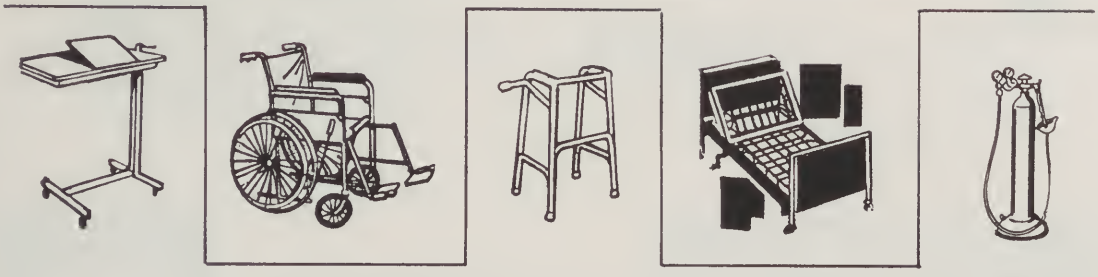
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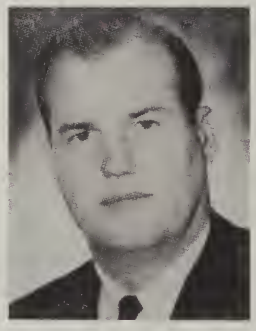
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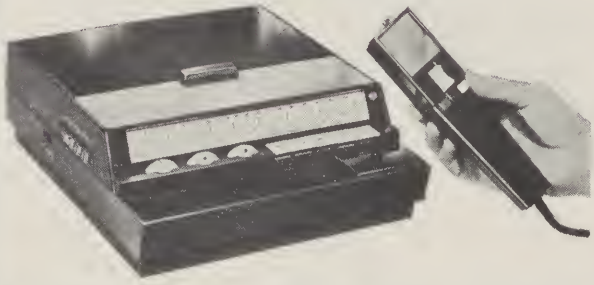
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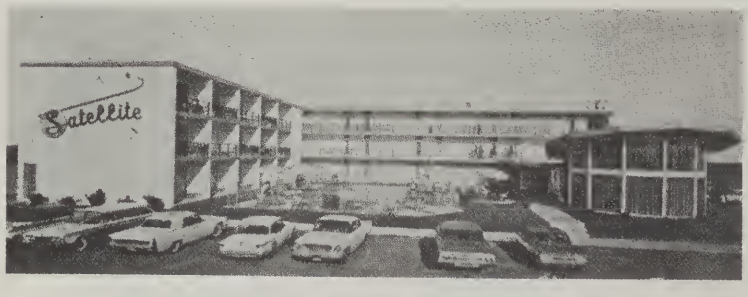
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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver-function tests advisable during protracted therapy.

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Maryland State Medical Journal

FICIAL PUBLICATION OF THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

VOLUME 17, NUMBER 6
JUNE 1968

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References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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Precautions—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Acute gonococcal anterior urethritis in males has been treated effectively with a single dose of 600-900 mg of DECLOMYCIN Demethylchlortetracycline. Individuals unable to tolerate large single doses due to gastrointestinal side effects may be treated with 150 mg every 6 hours for a minimum of 4 doses or 300 mg every 12 hours for a minimum of 2 doses. Females should be treated with a dosage of 150 mg every 6 hours or 300 mg every 12 hours until a cure is effected.

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Postgraduate Course—Infectious Disease: Mechanisms and Manifestations: University of Maryland School of Medicine, Baltimore. Co-directors: Theodore E. Woodward, MD, FACP, and Richard B. Hornick, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

JUNE 20, 1968
HEART ASSOCIATION OF WESTERN MARYLAND

Annual Meeting: Contact: Heart Association of Maryland, 415 N. Charles St., Baltimore, Md. 21201.

JUNE 21–23, 1968
HEART ASSOCIATION OF MARYLAND

Weekend With Doctors: Western Maryland College, Westminster, Md. Contact: Heart Association of Maryland, 415 N. Charles St., Baltimore, Md. 21201.

JUNE 24–26, 1968
UNIVERSITY OF WASHINGTON SCHOOL OF MEDICINE, SEATTLE

Postgraduate Course—The Newborn: Guest Faculty: Mary Ellen Avery, MD; Sydney Gellis, MD; L. Stanley James, MD; Richard T. Smith, MD. Contact: University of Washington School of Medicine, Division of Continuing Education, Seattle, Wash. 98105.

JUNE 28, 1968
FREDERICK COUNTY HEART ASSOCIATION/FREDERICK MEMORIAL HOSPITAL POSTGRADUATE EDUCATION COMMITTEE

Panel Discussion: Contact: Heart Association of Maryland, 415 N. Charles St., Baltimore, Md. 21201.



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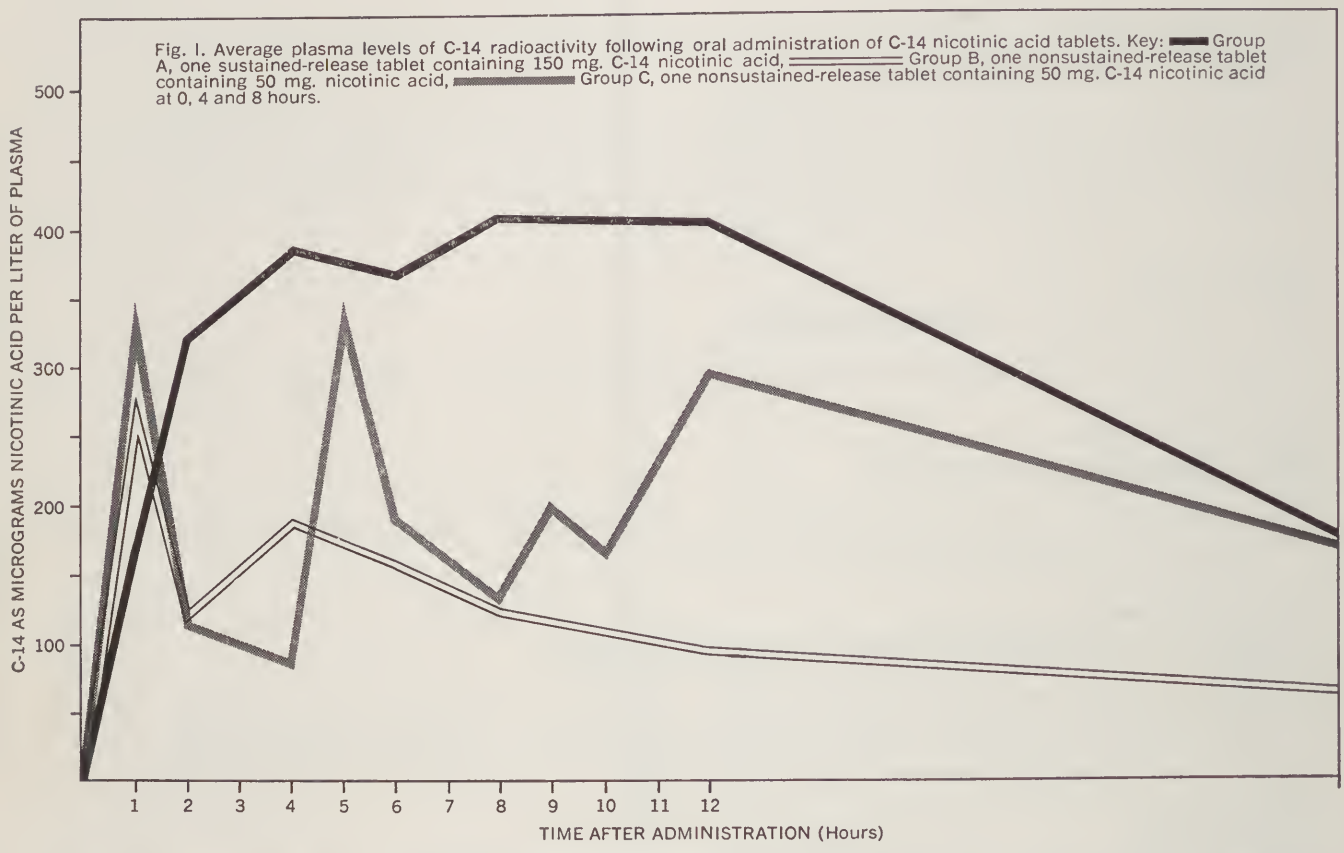
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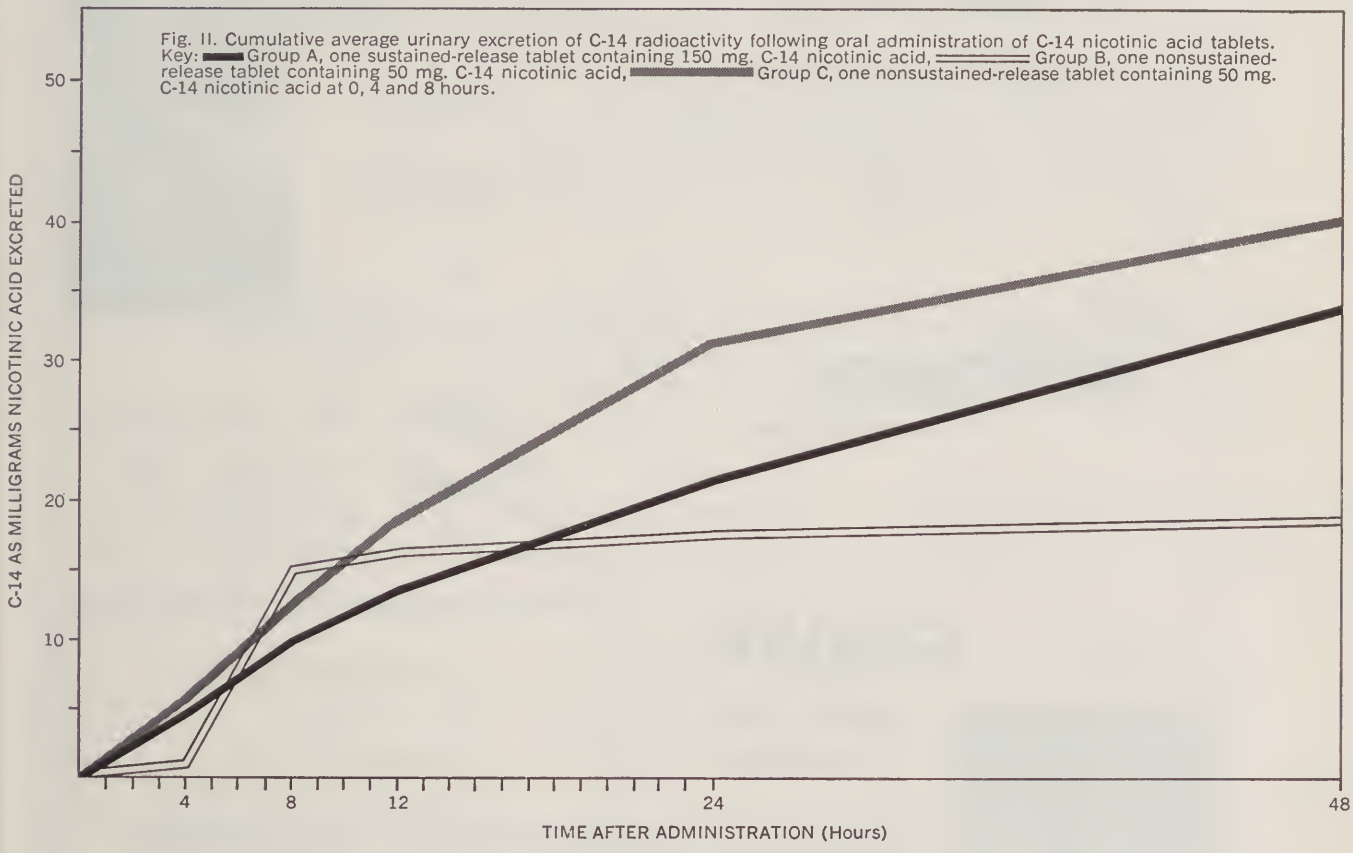
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References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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executive secretary's newsletter

June, 1968

REFERENCE COMMITTEE HEARING

The date chosen for the meeting of the Reference Committee to consider resolutions up for discussion at the Faculty's Semiannual Meeting is:

THURSDAY, AUGUST 15, 1968 at 8:00 p.m.

As of this date, the only resolution up for consideration is Resolution 6A/68, referred to the Committee by the House of Delegates on Friday, April 19, 1968.

VOTED OUTSTANDING CHAPTER

The Maryland Chapter, American Academy of Pediatrics, has received a $2,500 award as the outstanding chapter of the year. The check will be presented to Wilson Grubb, M.D. at the annual meeting of the American Academy in Chicago.

LEGISLATIVE ACTIVITY

In the early part of May, the Governor signed into law House Bill 21, establishing the Commission on Medical Discipline.

At the same time, he vetoed House Bill 574, that would have established that physicians shall prescribe by generic name the drugs used in Federal grant programs.

NEWS NOTES

Frederick M. Zerzavy, M.D., of Baltimore, is currently serving in the AMA Volunteer Physicians for Viet Nam program.

Samuel P. Asper, M.D., Baltimore, has been named President-elect of the American College of Physicians.

Isadore Kaplan, M.D., Baltimore, has been elected president of the American Association of Railway Surgeons.

E. H. Silverstein, M.D., Baltimore, has been certified as a Diplomate of the American Board of Dermatology.

E. F. Shaw Wilgis, M.D., is now practicing General and Hand Surgery at 5820 York Road, Baltimore.

SPECIALTY MEETINGS

Specialty society meetings at the Semiannual session include: Surgeons, Psychiatrists, Diabetes, Rheumatic Diseases and Ophthalmologists.

ITEMIZED BILLS UNDER MEDICARE

At the AMA Houston meeting, physicians were urged in a resolution adopted there, that they itemize bills for professional services rendered to their Medicare patients.

The local carrier, Maryland Medical Service, Inc. is faced with increasing problems in processing such bills because of lack of information which, in many cases, the patient cannot provide.

The cooperation of all physicians is urged.

MEDICAL CARE UTILIZATION SURVEY

A Medical Care Utilization Survey is currently in progress in the Metropolitan Baltimore area of the State. The survey is intended to find out from patients how they received medical care and for what reasons.

In addition to this survey, some physicians will be asked questions dealing with their practices.

Members are provided this information in the event they are approached in this connection.

EDUCATIONAL MAIL-IN

The offer of pamphlets for physicians' patients is still drawing daily receipt of mail-in cards at the Faculty offices. Geared to save the busy physician's time, the method provides an easy mechanism for patients to receive authoritative material on subjects of concern to them.

Physicians who wish postal cards for distribution to their patients may request them through the Faculty office. Full details will be sent.

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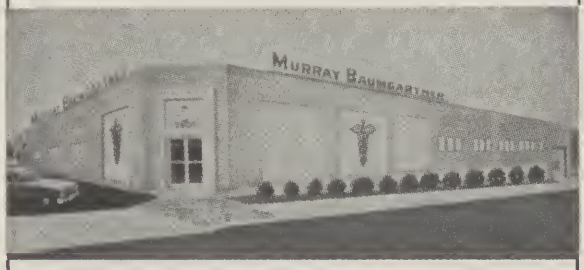
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Book Reviews

HEREDITY, DISEASE, AND MAN: Genetics in Medicine by Alan E. H. Emery, MD, University of California Press, Berkeley, Calif. 1968.

This new series of books is intended for serious readers who wish to learn more about current medicine but who cannot and should not be expected to read textbooks or scientific journals intended for physicians and medical students. This and succeeding volumes will be useful to students in the biological sciences and to those whose work brings them into contact with medical issues. Each book will be a concise, comprehensive and illustrated essay on a major disease or body system and its fundamentally related parts, or a specialized area of research or an aspect of society that affects the public health.

SURGERY OF THE AGED AND DEBILITATED PATIENT by John H. Powers, MD, W. B. Saunders and Company, Philadelphia, Pa. 1968.

This volume has been prepared with emphasis on the particular problems and complications associated with surgery of the aged. The text has been prepared by many authorities.

The knowledge and information contained in this book should do much to alleviate the many physical and mental burdens of the aged; and render prophylactic, elective and urgent surgery safer and more acceptable during the declining years of man.

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CANCER EPIDEMIOLOGY: Methods of Study by Abraham M. Lilienfeld, MD, and Einar Pedersen and John E. Dowd. The Johns Hopkins Press, Baltimore, Md. 1967.

The purpose of this book is to fill a gap in the field of medicine that involves Epidemiology and the use of material already in the hands of physicians and others who may lack the knowledge to utilize their own material or make it available in a form that will permit its use by others.

This book is devoted to presenting the proper methods being used in cancer to those who, because of their interest in cancer problems, may wish to apply them.

HANDBOOK OF FRACTURES by Edgar Lee Ralston, MD, The C. V. Mosby Company, St. Louis, Mo. 1967.

What the profession needs in the way of an additional text on Fractures is a rather moot point. But the author makes it clear that this is a subject that medical students can never receive enough knowledge in; and one area in which a void exists.

The book is intended as an aid in the early steps of student training in this subject. It fulfills this function well.

INFECTIOUS DISEASES OF CHILDREN by Saul Krugman, MD, and Robert Ward, MD, The C. V. Mosby Company, St. Louis, Mo. 1968.

This fourth edition is not designed to be an all-inclusive text on infectious diseases, but comes remarkably near to it. Latest data on the use of virus vaccines, including mumps virus vaccine, as well as rubella virus vaccine; viral hepatitis, sepsis in the newborn and all of the most up-to-date data is part and parcel of this outstanding work.

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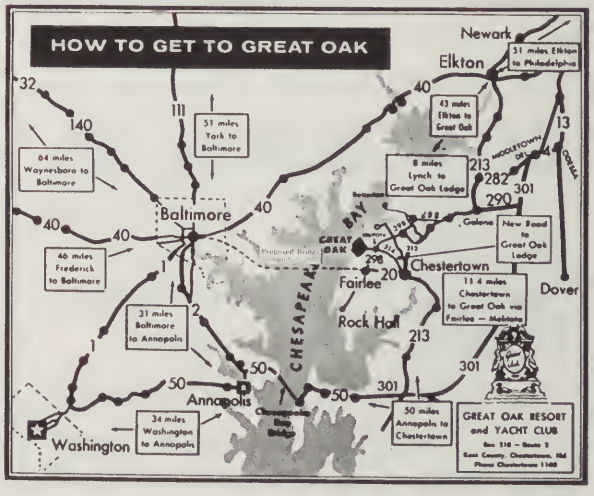
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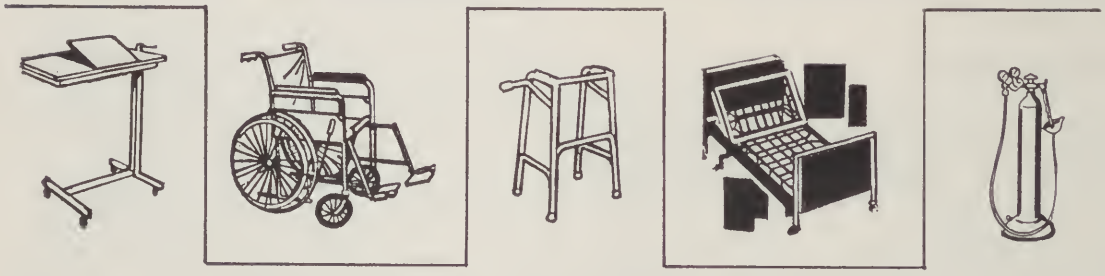
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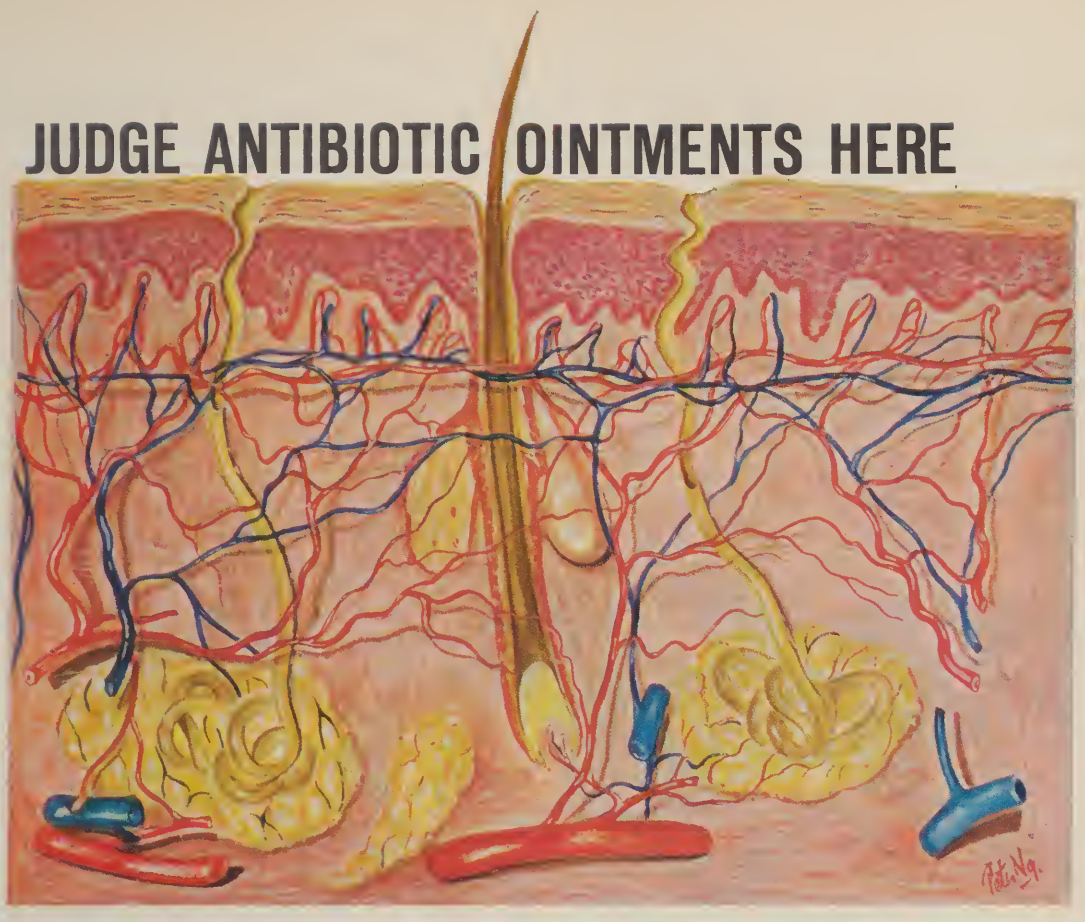
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Complete blood and platelet counts should be done prior to and at regular intervals during treatment with the drug (see recommendations under "Important Note and Precautions") to help in the early detection of serious bone marrow injury. Abnormalities in initial blood tests should rule out use of the drug. Also, patients should be made aware of such early toxic signs of a potential hematologic problem as fever, sore throat, mouth ulcers, easy bruising and petechial or purpuric hemorrhage. Should such signs appear, the patient should be advised to discontinue the drug and to report to the physician immediately.

Indication Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia. It is not a simple analgesic and should never be administered for relief of trivial facial aches or pains.
Contraindication Do not use in those with a known sensitivity to any tricyclic compound or in those being treated with M.A.O.I. agents. As long a period as possible should elapse before using Tegretol in patients who have been treated with M.A.O.I.'s, with a minimum of 7 days. In such cases, initial dosage should be low and the patient's reaction to gradual increments closely observed.
Important Note and Precautions Familiarity with the clinical symptoms which lead to an accurate diagnosis of true trigeminal neuralgia and with the complete prescribing information, careful patient selection, a thorough examination before treatment and close patient supervision throughout the treatment period are essential to the safe and effective use of this drug.
Where feasible, Tegretol should not be used in conjunction with any potent drug which may increase the possibility of toxic reactions.
In pregnancy, the drug should not be prescribed during the first trimester and thereafter only to patients in whom the clinical situation warrants the potential risk. It should not be administered to nursing mothers.
Patients with increased intraocular pressure should be closely observed during treatment with this drug because of its anticholinergic effect.
Because of the drug's relationship to other tricyclic compounds, the possibility of activation of latent psychosis and, in the elderly, of confusion or agitation, should be considered.
Dizziness and drowsiness may occur and patients should be cautioned about the hazards of operating machinery or automobiles and of engaging in other hazardous tasks.
Use cautiously in patients with a history of coronary artery disease, organic heart disease, congestive failure or liver disease.
Before initiating therapy, the following laboratory procedures should be performed:
1. Complete blood and platelet counts which, if abnormal, should rule out the use of the drug.
2. Baseline evaluations of liver function.
During treatment with Tegretol, the following laboratory procedures should be performed:
1. Complete blood and platelet counts should be done at intervals of one week during the first month of drug treatment, every two weeks during the second and third months, and at monthly intervals thereafter for as long as the patient is taking the drug. A trend toward a decreasing white blood cell count should suggest a dosage reduction and more frequent laboratory and clinical evaluations. Should this trend continue, the drug should be discontinued.
2. Liver function tests must be performed at regular intervals during treatment with this drug since liver damage may occur during therapy. The drug should be discontinued immediately in cases of aggravated liver dysfunction or active liver disease.
3. Periodic eye examinations, including slit-lamp, funduscopy and tonometry, are recommended for patients being treated with this drug since many phenothiazines and related drugs have been shown to cause eye changes.
4. Complete urinalysis and BUN should be done on patients treated with Tegretol because of observed renal dysfunction.
Adverse Reactions Dizziness, drowsiness, unsteadiness on the feet, nausea, vomiting, aplastic anemia, transitory leukopenia, agranulocytosis, eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormalities in liver function tests, cholestatic and hepatocellular jaundice, urinary frequency, acute urinary retention, oliguria with elevated blood pressure, albuminuria, glycosuria, elevated BUN, microscopic deposits in the urine, impotence, disturbances of coordination, confusion, headache, fatigue, blurred vision, transient diplopia and oculomotor disturbances, speech disturbances, abnormal involuntary movements, peripheral neuritis and paresthesias, depression with agitation, talkativeness, nystagmus, tinnitus, paralysis and other symptoms of cerebral arterial insufficiency, pruritic and erythematous rashes, urticaria, Stevens-Johnson syndrome, photosensitivity reactions, alterations in skin pigmentation, exfoliative dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, erythema multiforme and nodosum, aggravation of disseminated lupus erythematosus, gastric distress, abdominal pain, diarrhea, constipation, anorexia, dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills, adenopathy, lymphadenopathy, aching joints and muscles, leg cramps, conjunctivitis, left ventricular failure, aggravation of hypertension, hypotension, syncope and collapse, edema, aggravation of coronary artery disease and congestive heart failure. (Whether these cardiovascular effects are drug-related is not known. However, some of these complications have resulted in fatalities.) The necessity for discontinuing the drug should be dictated by the gravity and severity of the adverse reactions.
Dosage and Administration The drug should always be taken with meals, if possible.
Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, the dose should be increased in one-half tablet (100 mg.) increments every 12 hours until freedom from pain is achieved. To relieve pain, between 200 mg. and 1200 mg. per 24 hours may be necessary.
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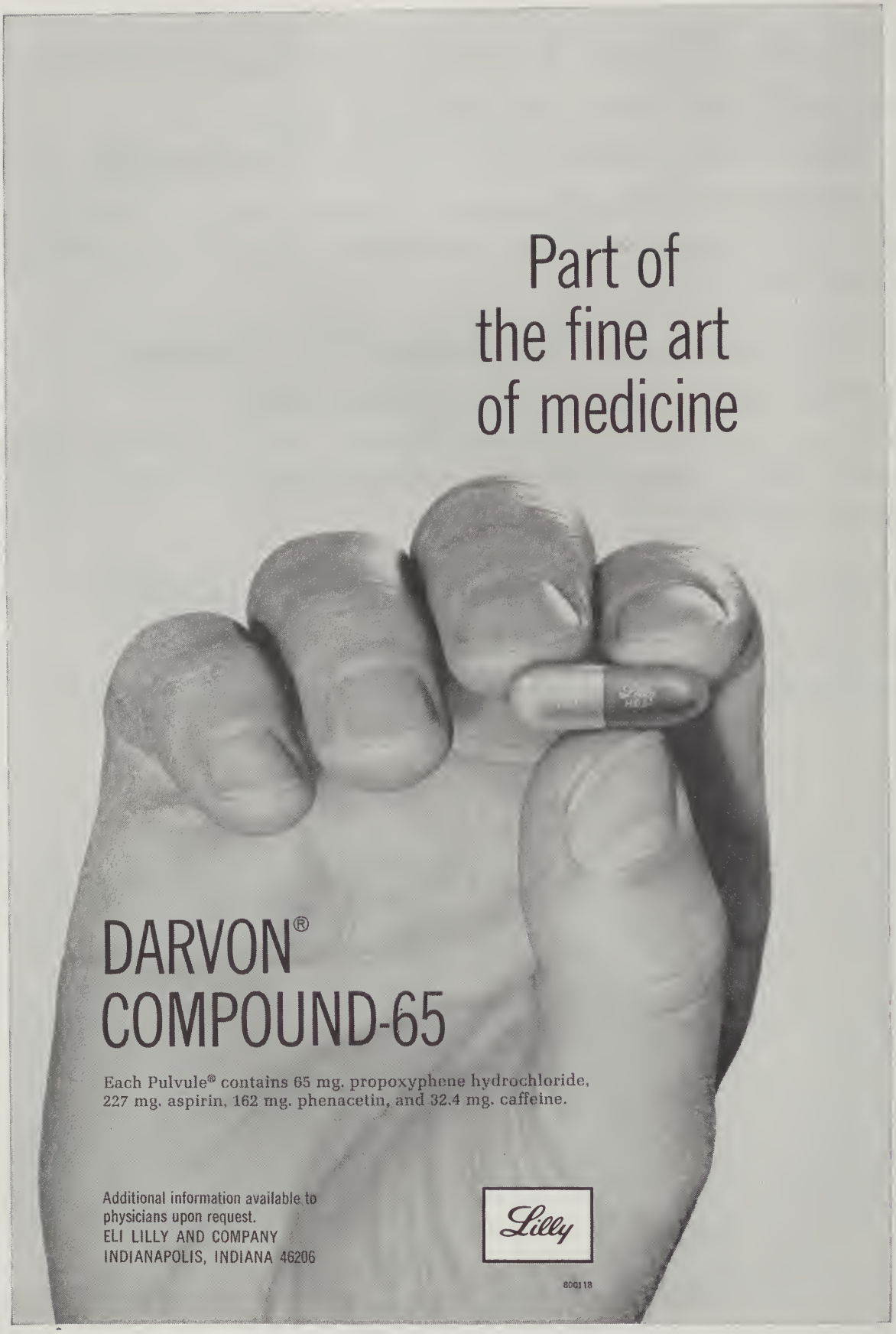
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THE MONTH IN WASHINGTON

The federal government has established a new agency and appointed two new advisory committees in the health care field.

The new agency is the National Center for Health Services Research and Development. The committees are:

1. The Medical Assistance Advisory Council that will advise the secretary of Health, Education and Welfare on matters relating to federal-state medical aid programs.

2. A panel to give the social security commissioner advice on experiments to find new methods of reimbursing hospitals and physicians for health care under medicare and other federal health programs.

Health, Education and Welfare spokesmen said the new center will work with universities, industry, hospitals, practitioners and research institutions to seek new ways of delivering health care. The new center was authorized by Congress last year at the Johnson Administration's request.

"The ultimate goal of the center is to aid practitioners and institutions involved in health services to improve the distribution and quality of services and to make the best possible use of manpower, funds, and facilities," said Philip R. Lee, MD, assistant HEW secretary for Health and Scientific Affairs.

The immediate goals of the center were listed as:

☐ More efficient utilization of health personnel, including the development of new types of health workers at the professional, technical and auxiliary levels.

☐ Increased productivity and better management of all elements of the medical care system to improve quality and moderate rapidly rising costs.

☐ Technological innovation, for immediate application, to achieve cost reduction and quality improvement.

☐ To survey and analyze health systems, including costs and financing and to test new concepts and systems of health care delivery.

☐ To recruit, train and develop personnel for health services research, including the establishment of regional, non-Federal centers for health services research and training.

☐ Collection and correlation of existing information on health services delivery for planning and organization design.

☐ Initiation of systems' studies of institutional design, construction, equipment and maintenance and support construction of cost-saving innovations.

Director of the center, which is under the newly created Health Services and Mental Health Administration, is Paul J. Sanazaro, MD, who had directed education and medical care research for the Association of American Medical Colleges since 1962.

HEW said the advisory council would be consulted on program development and practical operational problems involved in Medicaid (Title XIX of Social Security). Such programs are in operation in 38 states, Guam, Puerto Rico and the Virgin Islands. Rashi Fein, PhD, a chief economist at the Brookings Institution, was named chairman of the 21-member council which includes six physicians: John B. Farley, Pueblo, Colo.; Thomas B. Georges, Pennsylvania health and welfare official; Amos N. Johnson, Garland, N. C.; Maynard Shapiro, Chicago, president-elect of the American Academy of General Practice; George W. Slagle, Battle Creek, Mich., chairman of the American Medical Association's Council on Medical Service, and Donald Smith, public health professor at the University of Michigan.

The Social Security Administration said the reimbursement panel would review proposals for experiments submitted by institutions and individuals in the health care and health insurance fields. After such reviews, it will be asked to recommend the ones it believes to have the greatest potential.

Nathan J. Stark, a Kansas City, Mo., businessman is chairman of the 17-member group. Four members are physicians: Solomon J. Axelrod, University of Michigan; Thomas W. Georges, Jr.,

Pennsylvania welfare official; Donald R. Hayes, Springfield, Mass. and Pierre J. Salmon, San Mateo, Calif., county public health and welfare official.

* * * *

The American Medical Association urged that Congress appropriate maximum amounts for support of medical education.

The AMA position was outlined by C. H. William Ruhe, MD, director of the AMA's division of medical education, at a hearing of a House appropriations subcommittee.

"We recognize the present concern of the Congress and the nation for an overall reduction in federal expenditures," Dr. Ruhe said. "However, we believe that the urgent need for more physicians merits the funding, to the fullest extent possible, of legislation supporting medical education . . .

"An urgent need exists in this country for more physicians to meet the health care needs of the American public. This need can only be met effectively by a major increase in the capacity of American medical schools to educate more physicians."

Dr. Ruhe noted that Federal aid to medical schools under the proposed Health Manpower Act of 1968 would not become available before 1970. Therefore, he said efforts must be made to secure the essential immediate increase in financial support through increased appropriations under existing law. He listed the Health Professions Educational Assistance Act, the Health Research Facilities Construction Act, the Medical Act, and the general research support authority of the National Institutes of Health.

* * * *

Gov. Nelson Rockefeller of New York and two other witnesses at a Senate subcommittee hearing supported national compulsory health insurance as a solution of the problem of rising health care costs.

The other witnesses were Olcott D. Smith, chairman of Aetna Life and Casualty Company, who expressed belief that private companies could work with the government effectively on such a program, and economist Victor Fuchs.

But Wilbur J. Cohen, Secretary of Health, Education and Welfare who favored the plan 20 years ago, said he now believes the government should move on other fronts. He said it would be difficult—a "monumentable task"—at this time



to achieve a workable and acceptable program of compulsory national health insurance. He did not foresee the United States following the pattern of European nations in adopting a monolithic central health system for the entire nation. He said this country is too large for a single plan but that the benefits under any various plans adopted should be relatively uniform for all Americans.

Cohen said first priority now should be given maternal and child health programs. He listed as other "must" programs the expansion of medical manpower and health facilities and the continued investment in health research.

Sen. Abraham Ribicoff (D.Conn), chairman of the subcommittee holding hearings on health care costs, also said that the emphasis now should be on more immediate solutions. He said that his experience with the fight over medicare had convinced him that it would be a long time before Congress would accept compulsory national health insurance.

He said that the first week of the hearings "made clear that a health care system in America must include everyone—public and private organizations, insurance companies, the Blues, the voluntary hospitals, nursing homes, medical societies, individual private practitioners, those who practice medicine in groups, and state, local and federal agencies."

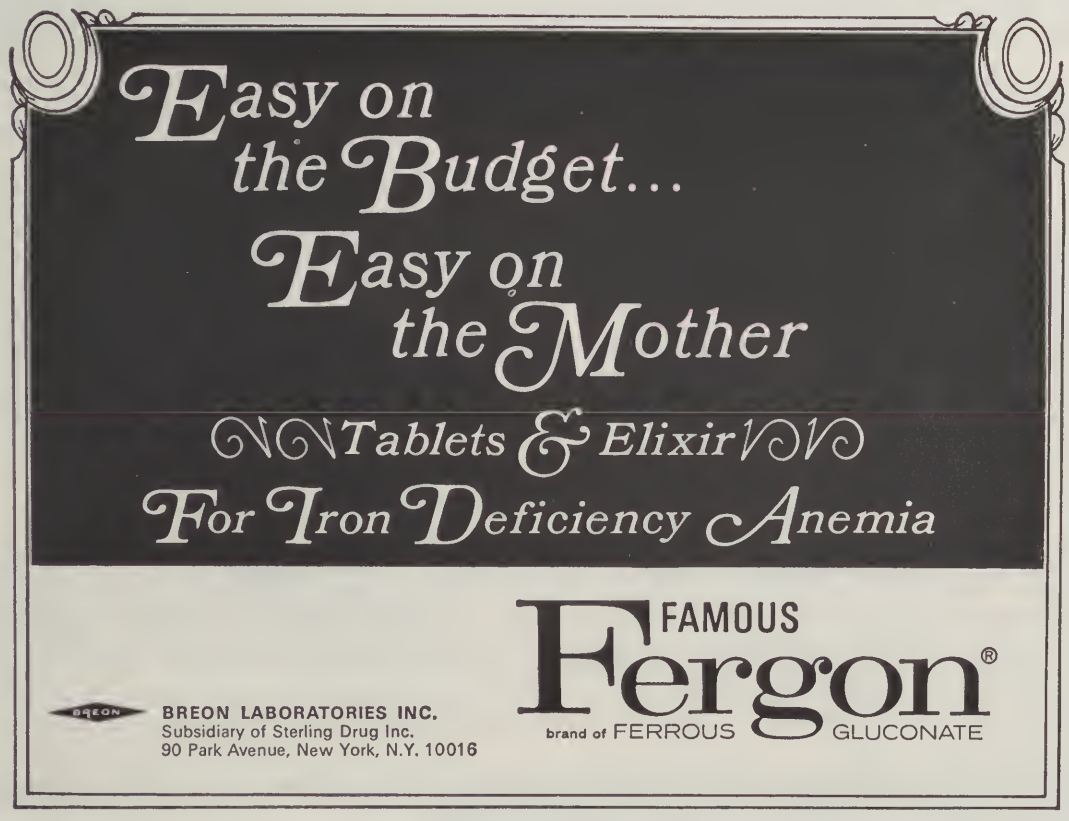
* * * *

Manufacturers of oral contraceptives are being asked by the Food and Drug Administration to revise uniform labeling for the products to reflect findings from research in Great Britain that there is an association between the use of oral contraceptives and thromboembolic diseases.

Herbert L. Ley, Jr., MD, director of the FDA's Bureau of Medicine, notified the manufacturers of the publication of the British reports in the April 27 issue of the *British Medical Journal*. He called the companies to a Washington meeting for discussion of "prompt revision of uniform labeling."

Proposed labeling changes, based on preliminary results and unofficial reports of the British findings, had been submitted to U.S. manufacturers by the FDA last month.

The proposed new FDA labeling would reflect the findings of the British studies and would be aimed at prescribing physicians, an FDA spokesman said.



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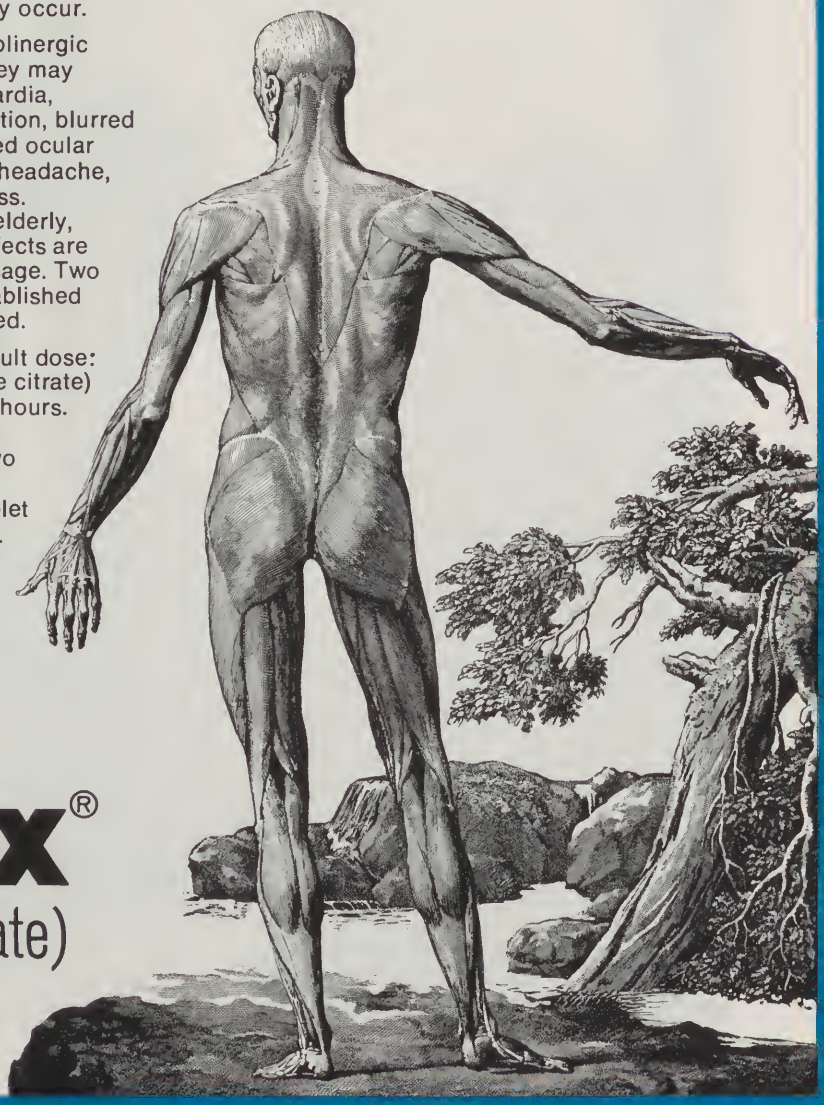
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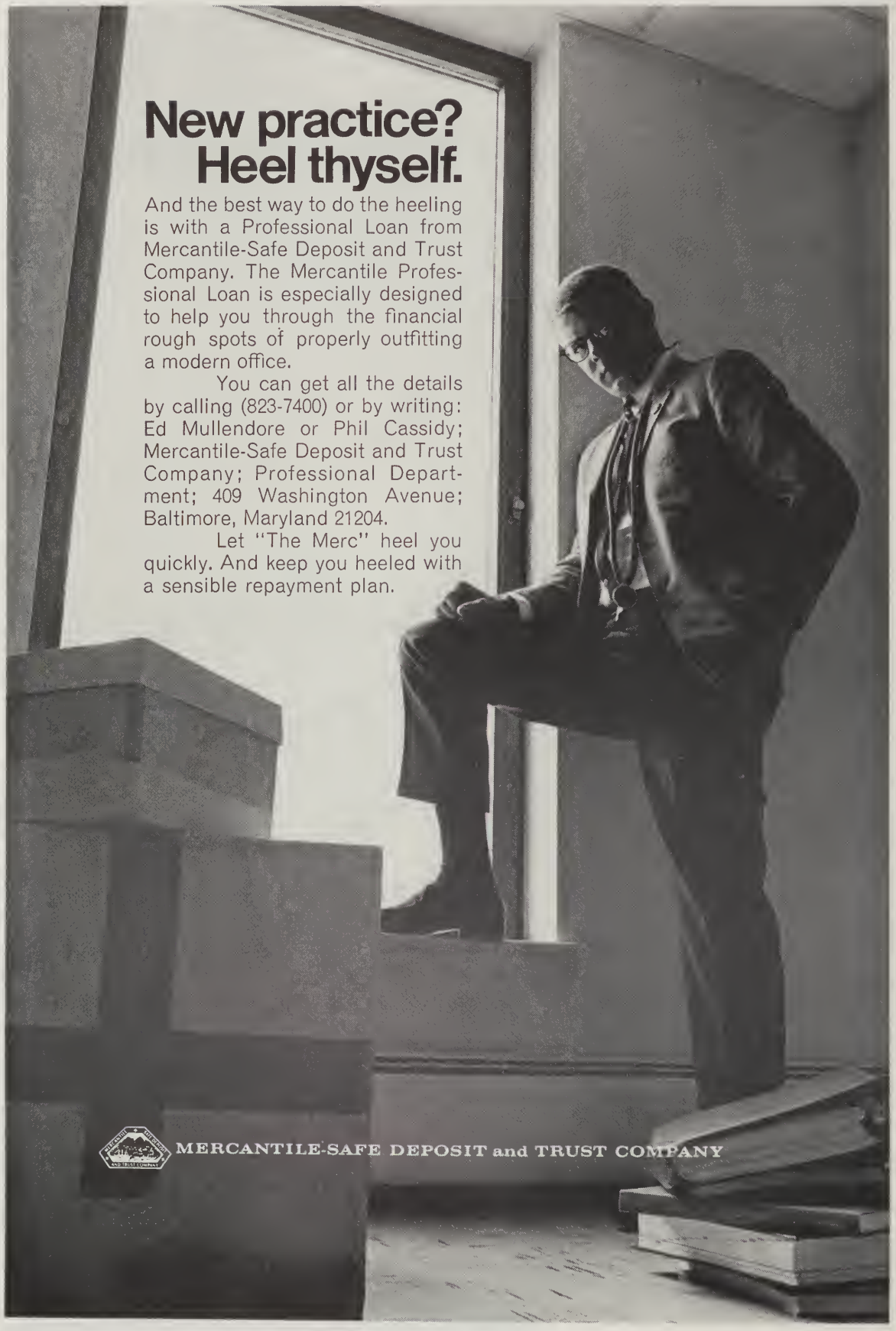
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American Heart Association Research Fellowships and Grants

Applications are being accepted by the American Heart Association for research support for the fiscal year, July 1, 1969 through June 30, 1970.

ESTABLISHED INVESTIGATORSHIPS: Individuals with proven ability to conduct independent research—usually with 3 years postdoctoral research experience and under age 40 when applying.

Term: 5 years; Stipend: $13,000 with $1,000 annual increment plus fringe benefits; Departmental Grant: $1,000 per year.

Application deadline—September 15, 1968.

FOREIGN VISITING SCIENTISTS: American investigators may invite experienced foreign scientists to the United States for research collaboration.

Term: 3-12 months; Stipend: Negotiable per comparable positions at host institution plus travel allowances.

Application must be initiated by American host scientist. Primary deadline September 15, 1968. Additional applications will be received until December 31, 1968 subject to availability of funds.

GRANTS-IN-AID: Support of an investigator's research project in a qualified institution.

Term: 1-3 years.

Application deadline—November 1, 1968.

BRITISH-AMERICAN RESEARCH FELLOWSHIPS: In cooperation with the British Heart Foundation, support for United States citizens planning to work in an institution in Great Britain. Two years experience when applying usually required.

Term: 1 year; Stipend: $7,500 plus dependency and travel allowances; Departmental Grant: $750.

Application deadline—September 15, 1968.

EMERGENCY GRANTS: Limited amounts in unusual circumstances. Not to exceed 1 year.

Application forms may be requested at any time by telephone or explanatory letter from the Director of Research, American Heart Association, 44 E. 23rd St., New York, N. Y. 10010.



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Good Samaritan

The Good Samaritan Hospital, a new 284-bed institution now nearing completion at Belvedere Avenue and Loch Raven Boulevard, has released an official "philosophy and statement of purpose," authored by John Collins Harvey, MD, medical director, and approved by the board of trustees, which details and clarifies the exact role of the new institution in the community.

Dedicated to carry out the specific intentions of the founder-benefactor, Thomas O'Neill, the hospital's purpose is to provide care for chronically ill patients who can improve with appropriate treatment. This admission philosophy presupposes dynamic care programs designed to assist each patient to his maximum performance level and potential, according to the document.

Acute intensive care and extended hospital care, as well as ambulatory and hospital-based home care, will be provided to help each patient to his maximum benefit, Dr. Harvey said, emphasizing, however, that there will be no emergency room.

Other highlights of the approved philosophy are:

☐ Responsibilities of the hospital include research activities at both basic and applied levels in a number of chronic illnesses, involving medical and paramedical disciplines and teaching programs for personnel in the health care field. It is anticipated that all patients admitted to the hospital will participate in the hospital's research programs under norms established by the hospital's committee on therapeutics and clinical investigation.

☐ Admissions will be handled through a preadmission service which will evaluate each patient's illness as it relates to the type of program and care the Good Samaritan Hospital is best equipped to provide.

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☐ Facilities and staff are being developed for the care of patients with these chronic diseases: renal, including those oriented to the support of renal transplantation, hemorrhagic disease, obstructive respiratory disease, diabetes, tissue metabolic disorders such as rheumatoid arthritis, gout, osteoarthritis, various neurological diseases and circulatory diseases.

☐ The hospital will not develop care programs for patients who have cancer, pulmonary tuberculosis or chronic psychiatric disorders as their main reason for hospitalization, nor will custodial care be offered.

☐ Since Baltimore provides excellent in-hospital facilities for children in the pediatric age group, in general, Good Samaritan will limit their admissions to patients fourteen years of age or over. Race, color, creed or national origin will not be factors in admission.

☐ A comprehensive and total focus will be given each individual patient from medical, nursing, therapeutic, psychological, social and spiritual service, which will include careful planning for home and out-patient care after the patient has received maximum benefit within the hospital.

☐ "The hospital realizes its responsibility to provide the best possible continuity of care for each patient and for this purpose will establish close working relationships with each patient's family physician and community agency."

☐ The hospital will also cooperate closely with other community agencies in creating and conducting programs designed to upgrade and refine the skills and competence of its total personnel to constantly improve the quality of patient care.

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Baltimore City Medical Society

Nine of the members of the Board of Directors of the Baltimore City Medical Society met at 1211 Cathedral St., Baltimore, Md., on April 23, 1968, at 4:30 P.M. for their monthly meeting. This was a rescheduling of the April 9th meeting.

The meeting was called to order by Frank Kaltreider, MD. The minutes were read and approved for the meeting of March 12, 1968.

Philip Wagley, MD, reported on a meeting of the Policy and Planning Committee which was held on March 6, 1968. Those in attendance at this meeting included Frederick Adams, MD, Gordon Cader, MD, John Wiswell, MD, and Dr. Wagley, Chairman.

Of the numerous items of importance discussed, it was the recommendation to the Board of Directors to support the hospital directors and medical schools attempt at training paramedical personnel. This suggestion was followed by a lengthy discussion and the ultimate support of the Board for this proposal. It was suggested that the directors of the hospital, as well as the deans of the medical schools, be notified of the Society's interest in this program and their pledge to support its implementation.

Suggestions are to be forwarded to Arthur Siwinski, MD, President of the Medical and Chirurgical Faculty of the State of Maryland, for recommendations for appointments to a list of committees of the State Society. These committees include: Med-Chi Insurance Trust, Bylaws Committee, Medical Economics Committee, Editorial Board, Committee on Emotional Health, Finance Committee, Legislative Committee, Liaison Committee, Mediation Committee, Medical Emergency Disaster Service Committee, Medicolegal Committee, Membership Committee, Occupational Health Committee, Committee on Postgraduate Education, Preventive Medicine and Public Health, Contractual Arrangements Committee, Public Relations Committee. It was decided the individual members of the Board would make personal recommendations directly to Dr. Siwinski for his consideration.

Several representatives of the United Appeal of the Community Chest appeared at this meeting and pointed out to the Board of Directors that in the past the membership of the Society has participated poorly in the annual fund drive sponsored by The Community Chest. In the year 1966, participation included only 46.5% of the BCMS membership. It was the plea of Mr. E. Clinton Bamberger, Jr., who represented the United Appeal, that the Board of Directors sponsor an organized drive soliciting the membership for contribution to The Community Chest. It was decided by the Board that literature soliciting the membership would be mailed to the membership with the help of the office staff of The Community Chest.

A letter was read to the Board of Directors from Sheppard Kaplow, MD, Secretary-Treasurer of the Medical Staff of the Sinai Hospital of Baltimore, requesting the Board to consider changing the meeting of the Medical Society from Friday evenings to another evening in the week for ecclesiastical reasons. It was decided by the Board to send a questionnaire to the membership polling their consensus of this consideration.

A letter was read from Morris J. Wizenberg, MD, President of the Baltimore City Unit of the American Cancer Society, requesting that the Baltimore City Medical Society prepare and distribute to its members a monthly list of major talks to be given in the community. The Board of Directors supported this idea and are planning to make arrangements through the American Cancer Society to accomplish this feat.

A letter was read from Robert J. Wilder, MD, Baltimore City Medical Society representative to the Commission on Operational Medical Planning for Civil Disturbance. Dr. Wilder reported in detail a meeting held on March 16th. Numerous aspects of the Emergency Disaster Plan were discussed at this meeting and the major role of physicians at their hospitals was defined. This commission also requested the Medical Society to have available a list of physicians who could attend one of the refugee centers outside the disaster area where individuals who are trying to escape the disturbance are to be housed.

Frank Furstenberg, MD, Chairman of the Professional Relations Committee, presented a problem case to the Board of Directors. It was the opinion of the Board that this case should be referred to the Mediation Committee of the Medical and Chirurgical Faculty of the State of Maryland, for final disposition.

The meeting was adjourned at 6:45 P.M.

ARTHUR E. COCCO, MD
Journal Representative

Editorial

Maryland State Medical Journal
Vol. 17, No. 6
June, 1968

Is the Medical School Philosophy Responsible for the Health-Manpower Shortage?

During a recent Health-Manpower Study, commissioned by the Advisory Council on Higher Education, the following conclusion was reached . . .

> **"If current trends continue, there will be a moderate shortage of physicians in Maryland by 1980."**

We of the Medical and Chirurgical Faculty of the State of Maryland cannot agree.

We are of the opinion, justified by our discussions with knowledgeable people, that a shortage currently exists and that by 1980 this *shortage will be acute.*

At a recent Faculty Council meeting, discussion was centered around ways and means of providing more "first-line" physicians capable of and willing to devote their time and energies to preventive medicine and the early stages of illness. There are many proposed solutions to this problem.

Building a third, State-supported medical school has been one proposal but this long-range program will not help alleviate our present problem. Increasing the productivity of physicians already in practice is another proposed solution but it raises the question as to whether or not physicians will be willing to spread themselves thinner—many already are working at peak capacity.

It also has been suggested that lesser-trained individuals be taught to perform tasks the highly-trained physician can delegate to them. This, of course, would have to be done on an individual basis depending on the ability and type of training of such "lesser-trained" people.

An increase in the number of medical students being admitted to the various freshman classes is being promoted actively by both Maryland medical schools and will help, in a small way, to increase the supply of physicians seeking to enter private practice. However, present facilities and the necessary high quality of training limit the total number of enrollees the schools are able to accommodate.

The medical schools could increase the number of physicians offering their services to the public by a change in their philosophy of teaching. Too often the private practice of medicine is denigrated—too much stress is placed on research and hospital-based practice. Too often a patient is treated as a disease entity with a disease to be conquered, rather than as an individual to be reassured and palliated. Too often a patient is used for a battery of tests on some research project.

We believe it is time for medical school faculties to give serious thought to de-emphasizing the importance of research and stressing the seriousness of the health-manpower shortage and the need for re-creating the physician/patient relationship in order to provide necessary health care to the public. By so doing, the medical faculties will benefit all—the profession and the public alike.

ARTHUR G. SIWINSKI, MD
President

ANNUAL REPORTS TO THE HOUSE OF DELEGATES

1968

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REPORTS

To The House of Delegates

The material contained in these Reports is informational only and does not reflect Faculty policy until such time as action is taken on them by the House of Delegates.

Recommendations and items contained herein are only up **for consideration** at this time.

COUNCIL

Mr. Chairman and Members of the House of Delegates:

During the past year, the Council held its six regular sessions, and one special session. The special session was devoted to discussion of and final approval of a proposed Retirement Program to be made available to Faculty members and their employees who are eligible. Full details have been sent to all members. The initial enrollment and response was overwhelming.

The Executive Committee also held 10 meetings, at which items of importance were discussed and, where necessary, disposed of.

At the regular Council meetings routine matters were handled as follows:

Ratified legal defense for various physicians who requested it.

Gave consideration to provision of such defense to physicians who requested it but were not eligible because of late payment of dues for the year in which the alleged offense occurred.

Heard of settlement of various cases and amounts of such settlements, if any.

Approved remission of dues for members whose components requested it because of illness, financial hardship or other reasons.

Received financial reports from the Treasurer and approved them.

Ratified and made appointments to various agencies, authorities and Committees or Commissions.

Adopted as recommended or adopted as amended various recommendations from Committees. A complete list of these actions is appended at the end of this report for the record.

Routinely evaluated staff salaries and made adjustments as recommended within salary ranges adopted by the Executive Committee.

Authorized employment of legal counsel for an additional year and established the rates of payment for his services.

Adopted the 1968 operating budget.

Recommends the following members be granted Emeritus Membership, all of whom have been approved for such membership by their Component Society:

Through Baltimore City Medical Society: **N. Floyd Adams, Jr., MD (now of Westminster); J. Wesley Edel, MD; Byruth Lenson-Lambros, MD; Ernest L. Stebbins, MD, *all retired.***

Through Baltimore County Medical Association: **Frederick Allen Holden, MD, Towson; Harry Butler, MD, Owings Mills, *retired.***

Through Montgomery County Medical Society: **Samuel L. Tabb, MD, Silver Spring.**

The following policy decisions were taken on the dates indicated:

Council, June 8, 1967

The Council voted to adopt the following:

That the Pharmaceutical Association be advised that it is the responsibility of the physician to write and refill prescription orders; and that it is not clear as to what is meant by "transmit my authorization," as well as there being some question as to there being an indication of the specific "named" office assistant.

The following substitute motion was adopted:

The medical profession wishes to go on record as supporting the concept of Title 19 but is unwilling in receiving State payments to continue its practice of subsidizing this program as in the past and will provide to the public the promised medical care only on a Usual, Customary and Reasonable fee basis.

It is understood that authority is granted to the appropriate Faculty representatives to meet with State Officials to convey this information to them; and that the Executive Committee is authorized to contact the Federal Government in this connection to express its concern or unwillingness to participate in the program because of the manner in which it is being operated.

Alcoholism

The Council voted to adopt the following recommendations from the Committee on Postgraduate Education, Preventive Medicine and Public Health:

(a) That the Faculty endorses a three day workshop on Alcoholism Programming for Public Health Professionals to be held on November 27, 28, and 29, 1967, and that Doctor Conrad Acton be appointed to serve as the Faculty representative to the program planning committee.

(b) That the Medical and Chirurgical Faculty support the Alcoholism Control Bill proposed by Senators Javits and Moss, now under discussion in the Labor and Public Welfare Committee of the United States Senate.

Aging

The Council voted to adopt the following recommendations from the Committee on Postgraduate Education Preventive Medicine and Public Health:

(a) That the Faculty support, where need is demonstrated, community sponsored nursing home facilities in all communities in Maryland for extended care, nursing home care, and custodial or domiciliary care.

(b) That each local Commission on Aging stimulate activity in programming community sponsored nursing homes.

Handicapped Children's Program

The Council approved adoption of the following recommendation of the Subcommittee on Standards of Care of Handicapped Children under the Medical Assistance Program:

> The Medical and Chirurgical Faculty of Maryland reiterates its support of the high standards of care offered through the State Crippled Children's Program, which stands ready to accept handicapped children particularly where special facilities are needed and are available for treatment. It also reiterates the concept that the Crippled Children's Program continue to maintain contact with the referring family physician and that encouragement be given to him for his participation in the follow-up and after-care of such patients. The Medical and Chirurgical Faculty goes on record as endorsing the continuance of the high standards that have been adopted and used in the operation of the State Crippled Children's Program.

Council, September 7, 1967

Prescription Blank Imprints

The following recommendation of the Liaison Committee was adopted as amended:

> Approval of the policy that prescription blanks printed for physicians after January 1, 1968, *not* contain *printed* information indicating refills.

It is understood that Faculty legal counsel recommends this; and that the Maryland Pharmaceutical Association is to be informed of this action.

X-Ray Policies of City and State Health Departments

The following recommendations of the Liaison Committee were approved:

> An educational program should be directed at private practitioners in an effort to influence their referring private patients to Radiologists rather than to Health Clinics, particularly when payment is being made by a third party with greater and greater frequency.
>
> If a pregnant woman under the care of a private obstetrician is in need of a chest X-ray, then she should be referred to a private Radiologist.
>
> Industry requiring a preemployment chest X-ray should be encouraged to contract with a private Radiologist whenever possible. The Health Department and the Maryland Tuberculosis Association should discourage the use of their facilities by industry for preemployment X-rays where it is felt that such an arrangement with a private Radiologist is feasible.

Recognition on Members' Deaths

The following recommendation of the Membership Committee was adopted as amended:

> An appropriate recognition at the time of their death be made of members or other deserving individuals who have worked on behalf of the medical profession. The determination as to the extent of the financial cost of such tribute, and the determination as to the qualifications for such tribute should be left to the discretion of the Executive Committee.

Executive Committee, November 11, 1967

Component Society Histories

The recommendation of the Policy and Planning Committee which reads as follows was adopted:

> "Up to $1,000 per year be appropriated for the preparation of a history of all component medical societies, with such being done over a period of time."

Council, November 16, 1967

Classified Telephone Listings

Mr. J. C. C. Justis, Jr., Directory Supervisor-Yellow Pages Development of the C & P Telephone Company, joined the meeting at this point for discussion of this item. After his presentation, he was excused.

The Council then voted to adopt the following amended policy with respect to such listings, as proposed by the Mediation Committee:

> Recognizing that a single, State-wide policy should be in existence with respect to physician listings in the "yellow pages" or classified telephone directory listings, because many telephone books cross over political subdivision lines, the Mediation Committee recommends adoption of the following policy:
>
> 1. Listings shall be made under the heading Physicians and Surgeons. It is understood that where a physician has a specialty that warrants listing under another heading, this is permissible (such as Clinical Laboratories).
>
> 2. Listings may include the following *ONLY:* name, address and phone number; office hours; an "if no answer" number; "physicians" or "surgeons" home address and telephone number.
>
> 3. Listings may be made *only* as follows: Practice limited to .....(Using only those specialties being approved by the American Medical Association or as modified and approved by a special liaison group to be named by the Faculty to work with the C & P Telephone Company).
>
> 4. Listing must be uniform in size and type face.
>
> 5. Display or box advertisements are strictly prohibited.
>
> 6. Listings may not be carried in a telephone directory where he does not have an office or residence, except in combined area directories where a listing may be published in all three yellow page directories, viz., Washington, Maryland Suburban, Virginia Suburban, Baltimore City, Baltimore Suburban West, Baltimore Suburban East.
>
> 7. It is preferable for physicians to list the letters "MD" following their name rather than the title "Dr." preceding their name, inasmuch as this leaves no doubt that the person listed is a medical doctor. At times, other types of "doctorates" can be listed in error.
>
> 8. Where multiple offices of a physician are listed, each office listing MAY NOT be preceded by the words "Physicians Office." The same applies to any other category of listing that might arise.
>
> 9. The Medical and Chirurgical Faculty may list, in the Metropolitan Baltimore area, a telephone number where the public may call to receive assistance in selecting a physician.
>
> 10. Items 2, 3, 4, 6 and 7 apply also to telephone directory listings in the White pages.

Dr. Townsend raised the question with respect to the Ocean City area, where a combined telephone book is issued. The listings include Somerset, Worcester and Wicomico Counties. He has asked the Telephone Company if physicians could be listed by communities for the convenience of summer visitors who are not familiar with the towns and cities in the area and are frequently confused when they need the services of a physician.

This question will be pursued with the C & P Telephone Company, inasmuch as Dr. Townsend has been unable to resolve this matter on a local basis.

Policy on Educational School Programs for Pregnant Girls

Frederick J. Heldrich, MD, joined the Council at this juncture to speak on behalf of Karl M. Green, MD, Chairman of the Faculty's Subcommittee on Child Welfare.

After discussion and comment, the following policy was adopted by the Council:

> The problem of providing for the education of the pregnant student in the Public School System must be solved on an individual basis in accordance with the needs of the student and the capabilities of the local school system. While hard and fast rules cannot be made, the following general principles should be heeded.
>
> 1. An opportunity should be provided for all pregnant girls to receive their education through all grade levels.
>
> 2. Of the two possible choices, home teaching vs. school teaching, the latter is to be desired, in most cases. The pregnant student may be accommodated in the regular classroom until transfer is recommended by the physician or principal or requested by the student.
>
> 3. Transfer at the appropriate time should be made to one of the following three settings.
>
> a. Special classroom in a regular school
>
> b. Special school
>
> c. Home teaching
>
> 4. The pregnant student shall be obliged to have routine prenatal medical supervision. A medical report containing information pertinent to her school activities shall be required on a monthly basis from each pregnant student.
>
> 5. The curriculum provided each pregnant student should be supplemented with appropriate material pertinent to the student's situation.

Library Committee Recommendations

Dr. Guerin offered the following recommendation:

> Pursuant to the resignation of Dr. Louis Krause from the chairmanship of this committee, the new chairman, Dr. Paul Guerin, and the committee recommend that the Faculty recognize Dr. Krause's long years of service in this capacity, either by establishing a Rare Book and History of Medicine department in his name, or other suitable gesture.

The Council voted that a committee be formed to consider this.

Action was deferred on the following Library Committee recommendation pending completion of the present study of the library collection being undertaken by Mr. Lee Ash, of Boston, Mass.:

> That the Council consider a long range building program so that the library can reply to the National Library of Medicine regarding application for a construction grant during 1968.

Formation of Special Gubernatorial Committee

Dr. Fisher then discussed the matter with the Council, following which the following motion was made:

> That the Faculty express its desire to cooperate in any way it can with the Governor and that it is willing to work with him in connection with the proposed special Gubernatorial project with the understanding that any Advisory Committee or group formed would be in an Advisory capacity only; and that the Executive Committee of the Faculty is authorized to appoint the Committee when and as it is needed.
>
> It is understood that the costs of administration or consultant services, if needed, would be provided by the Governor's office.

Executive Committee, December 7, 1967

> That it endorse the Baltimore Regional Planning Council as the preferred agency or group charged with health planning in the Baltimore Regional area; with the understanding that the local component medical societies involved will also endorse this group as the preferred agency, such contacts to be made by the Baltimore Regional Planning Council representatives.

Council, January 25, 1968

Physical Examination Form for School Sports Participation

The Council, as recommended by the Subcommittee on Medical Aspects of Sports, approved a proposed Physical Examination Form and Guidelines for medical evaluation of candidates for school sports, as amended.

Cancer Registry

> That a voluntary central cancer registry be established under the auspices of the Med-Chi, through its Cancer Subcommittee, the American Cancer Society, and the Regional Medical Program. This registry should be broad-based through the State Medical Society, and not restricted to individual institutions.

Use of Blue Shield for Medicaid Payments

The following motion was unanimously *reaffirmed:*

> On recommendation of the Executive Committee, the Council unanimously adopted the concept that Maryland Medical Service, Inc., be used for the purpose of making payments under Maryland's Medical Assistance Program, because of the cost savings that could be effected and because of its wide experience in this field."

This was originally adopted on January 19, 1967, by the Council.

Payment of Usual, Customary and Reasonable Fees Under Workmen's Compensation

The following recommendation of the Professional Medical Services Committee was adopted:

> The Professional Medical Services Committee recommends to Council that approval be given for the dispatch of a formal request to the Workmen's Compensation Commission requesting the substitution of the concept of Usual, Customary and Reasonable fee payment for a set fee schedule as is now utilized to physicians rendering care in Workmen's Compensation cases; and
>
> That the Faculty indicate its willingness to provide review mechanisms to provide information as to the reasonableness of any questionable fees; and
>
> That Faculty wishes to appear at any public hearing if one is called to present its viewpoints in this matter.

Respectfully Submitted,

Russell S. Fisher, MD,
Chairman of the Council

SECRETARY

Mr. President and Members of the House of Delegates:

Meetings held, and staffed, during the past year totaled 487.

Minutes of these sessions were prepared, meeting notices mailed and correspondence resulting from the meetings prepared. Complete records of all these sessions are available at the Faculty building.

Attempts continue to provide the most efficient administration possible. While we know that, on occasion, we err; we apologize recognizing that to err is human, to forgive, divine.

As part of the Faculty dues collection, a total of $6,720.00 was collected for AMA-ERF and this sum was presented to the Foundation at the AMA Clinical session in Houston, Texas, last November.

Respectfully Submitted,

WILLIAM A. PILLSBURY, MD, *Secretary*

EXECUTIVE SECRETARY

Mr. President and Members of the House of Delegates:

This April concludes 10 years of service with the Medical and Chirurgical Faculty. I firmly believe that much progress has been made in that time and that, gradually, we have assumed the initiative that we lost some time ago from either inertia or lack of time that physicians could devote to Faculty and relative activities.

We have developed over this period, enthusiastic committee chairmen and members; as well as willing workers. The cooperation and energies of the Committee members can be seen in the reports made by the Committees at this annual meeting.

The staff joins me in expressing appreciation for the courtesy and privilege extended to us during the year, both by the individual members, the officers and Committee chairmen and members.

Respectfully submitted,

JOHN SARGEANT

AD HOC COMMITTEE TO CONSIDER CHANGES IN THE MEDICAL PRACTICE ACT

Mr. President and Members of the House of Delegates:

This Committee was appointed almost two years ago. The first portion of its work has been accomplished and is now enacted into law, that of the Commission on Medical Discipline.

The second part of our responsibilities dealt with updating of the Medical Practice Act, the first since 1914. While the attached proposal entails mostly "housekeeping" changes, it also has several other substantive changes that are brought to your attention. No action on the part of the House of Delegates is needed at this time. This report is for information only and action will be taken and changes considered at the Semiannual Session of the Faculty in September.

This report has the concurrence of the Board of Medical Examiners, which has met with us on a continuing basis and went over the final draft at a meeting on April 3, 1968.

The substantive changes are as follows:

1. Deletion of specific subjects spelled out in the law in which examinations should be given. This will be established by regulation of the Board, making it more flexible so that changes can be made as medical school curriculums change.
2. Makes provision for the issuance of a Temporary Permit to practice medicine for the purpose of postgraduate teaching.
3. Deletion of the fee for examination, secrecy of the examinee's names, school of graduation, etc., the form of the license, all of which will be established by regulation by the Board.
4. Deletion of the requirement that a license be filed with the clerk of the circuit court of the jurisdiction in which the physician resides.
5. Deletion of the statement as to what constitutes advertising. The power to determine this in regulation form has been given to the Board.
6. No changes have been made in Sections:
   (11) Section dealing with the Commission on Medical Discipline enacted at the 1968 General Assembly.
   (13) Transplantation of organs section enacted at the 1968 General Assembly.
   (14) Parental Consent legislation enacted at the 1967 General Assembly.
   (15, 16, 17) Sections dealing with Abortions, enacted at the 1968 General Assembly.

Comments from individual members, component societies, delegates and officers are solicited. It is anticipated that, if approved at the Semiannual Session, this material will be presented to the Legislative Council for approval and submission to the 1969 General Assembly.

Respectfully submitted,

JOHN M. DENNIS, MD, *Chairman*
KARL F. MECH, MD
LEWIS P. GUNDRY, MD
WILLIAM A. PILLSBURY, MD

PROPOSED, REVISED MEDICAL PRACTICE ACT

April 15, 1968

Section 1. **Definitions.**

As used in this Act the following terms have the meanings indicated unless the context in which the terms are used indicates a contrary meaning:

(a) "Board" or "Board of Medical Examiners" means the Maryland State Board of Medical Examiners.

(b) "Commission" means the Commission on Medical Discipline of Maryland.

(c) "Faculty" means the Medical and Chirurgical Faculty of the State of Maryland.

(d) "Physician" means any person, including Doctors of Osteopathy, licensed to practice medicine in the State of Maryland in compliance with the provisions of this Act.

(e) "Practice of Medicine" means the exercise of the art and science of medical diagnosis, healing or surgery and shall include:

(1) Operating on, professing to heal, prescribing for or otherwise diagnosing or treating any physical or mental ailment or supposed ailment of another,

(2) Undertaking by appliance, operation or treatment to diagnose, cure, heal, prescribe for or treat any bodily or mental ailment or supposed ailment of another.

(3) Undertaking to treat, heal, cure or remove any physical or mental ailment or supposed ailment of another by mental or other process exercised or invoked on the part of either the physician, the patient or both,

(f) but shall not include:

(1) Administering anesthesia by a dentist provided that the dentist does not engage in such administration as a medical specialty,

(2) practicing anesthesiology or giving anesthesia for medical purposes by a dental surgeon who has regularly administered anesthesia in hospitals in this State for a period of not less than fifteen years prior to June 1, 1962,

(3) Selling proprietary or patent medicines,

(4) Practicing as an optician,

(5) Massage by hand, or other manipulation by hand but by no other means,

(6) Practicing the tenets of Christian Science by practitioners registered in the Christian Science Journal of the Christian Science Publishing Society,

(7) Practicing the following professions as registered, certified, or licensed and defined by law: chiropractic, dentistry, dental hygienics, midwifery, nursing, psychology, podiatry, practical nursing, optometry, pharmacy, physical therapy, osteopathy, except osteopaths required to be licensed under this Act.

Section 2. **The Board of Medical Examiners—Establishment.**

The Board of Medical Examiners of the State of Maryland is hereby established.

(a) It shall consist of eight Members who shall be elected by the Medical and Chirurgical Faculty of the State of Maryland at its annual meeting.

(b) The Members shall be physicians practicing medicine in the State of Maryland.

(c) A majority of the Members of the Board shall constitute a quorum.

(d) The Members shall serve a four-year term and may succeed themselves.

(e) Two Members shall be elected by the Faculty each year. The terms shall commence on the first day in June next following the election of the Member.

(f) In the event of a vacancy, the Board shall select a new Member to serve until his successor, elected at the next annual meeting of the Faculty, takes office.

(g) The Governor may remove any Member of the Board for cause.

Section 3. **The Board of Medical Examiners—Powers and duties.**

The Board shall have the following powers and duties:

(a) It shall establish examinations to be taken by applicants for license to practice medicine in the State of Maryland.

(b) It shall establish such other qualifications of applicants for license to practice medicine as the Board deems advisable.

(c) It shall license qualified applicants to practice medicine in the State of Maryland.

(d) It shall make an annual report to the Faculty.

(e) It shall issue certificates of professional standing to physicians for use in other jurisdictions.

(f) It shall authorize payment of expenses and compensation to its Members and others.

(g) It shall hold one or more meetings each year for examination of applicants. Notice of such meetings shall be made public.

(h) It shall maintain a list of all applicants for license in the State.

(i) It shall maintain a Registry of Physicians.

(j) It shall report to the Commission acts by a physician sufficient to revoke or suspend the license of, or reprimand, such physician.

(k) It shall have a secretary-treasurer and such other officers and employees as it deems necessary.

(l) It shall promulgate rules and regulations necessary to effect this Act.

Section 4. **Practice without license.**

1) No person shall practice medicine in this State unless he is licensed by the Board and is registered in accordance with the provisions of this Act except as hereinafter provided.

2) The following persons may practice without a license, but subject to rules, regulations and orders of the Board and Commission:

(a) A resident, intern or student, or equivalents at any hospital or office of physician who is engaged in hospital, dispensary or similar duties.

(b) A physician licensed by and residing in another jurisdiction when engaged in consultation with a physician in this State.

(c) A commissioned surgeon of any of the Armed Forces of the United States, the United States Public Health Service Hospitals and the Veterans Administration while engaged in the performance of duties incident to his commission.

(d) A physician who resides in a neighboring jurisdiction who is authorized under the laws of such jurisdiction to practice medicine therein and whose practice extends into this State, provided such physician shall not open an office or have a regularly appointed place to meet patients within this State and further provided that the same privileges are extended to phy-

sicians from this State by such neighboring jurisdiction.

Section 5. **Qualifications of applicants for license.**

The applicant for license must have the following qualifications:

(a) Be at least twenty-one years of age.

(b) Be of good moral character.

(c) Have the degree of Doctor of Medicine or Doctor of Osteopathy from a school in the United States or foreign country which has standards for graduation equal to those standards established by the Association of American Medical Colleges, the Council on Medical Education of the American Medical Association, or the American Osteopathic Association. Applicants having the degree of Doctor of Osteopathy must, in addition to the foregoing, have completed a one-year internship in an intern training program approved by the American Medical Association Council on Medical Education or such other agency recognized by the National Commission on Accrediting.

Section 6. **License without examination.**

1) The Board may license without examination the following:

(a) Applicants having the qualifications required by Section 5 and having certificates of proficiency and professional standing of the National Board of Medical Examiners or boards of medical examiners of other jurisdictions, the requirements of which are equal to those of this State, provided that such other jurisdictions grant the same privileges to licensed physicians of this State.

(b) Applicants licensed under the provisions of Sections 467-480, inclusive, of Article 43 of this Code and practicing and residing in the State of Maryland on June 1, 1967, and graduates on or after 1940 of schools of Osteopathy approved by the American Osteopathic Association, or graduates prior to 1940 of such approved schools of Osteopathy provided that said applicants have completed a refresher educational course approved by the Board and were practicing and residing in the State of Maryland on June 1, 1967.

(c) Nothing herein shall apply to Doctors of Osteopathy licensed to practice medicine in other jurisdictions.

2) Nothing contained herein shall alter or diminish the right of any osteopath licensed in this State on or before June 1, 1967, to practice Osteopathy.

Section 7. **License upon special examination.**

Applicants of conceded eminence and authority in the profession from other jurisdictions may be licensed by the Board upon special examinations provided such applicants have the qualifications required for examination in this State and have practiced medicine for ten years.

Section 8. **Temporary Permit to practice medicine.**

A Temporary Permit to practice medicine, without examination, may be issued by the Board to a qualified physician for the purpose of post-graduate teaching.

Section 9. **Examination of medical students.**

Medical students of those medical schools accredited by the Association of American Medical Colleges or the Council on Medical Education of the American Medical Association may apply for examination upon the following:

(a) Verified completion of the second year of study in such subjects as the Board deems proper.

(b) Verified completion of a complete course of medical study.

Section 10. **Registration.**

Physicians engaged in the practice of medicine in the State of Maryland shall register with the Board. The registration shall be a permanent record of the Board entitled "Registry of Physicians".

(a) The Registry shall be a public record and shall be evidence to the same extent as are Land Records as provided in Article 35, Section 40 of this Code.

(b) The Board shall provide for re-registration not less than every third year.

Section 11. **Commission on Medical Discipline of Maryland.**

1) Commission. The Commission on Medical Discipline of Maryland, hereby established and hereafter referred to in this section as the Commission, shall consist of the following persons:

(a) The President of the Medical and Chirurgical Faculty of the State of Maryland.

(b) Two practicing physicians appointed by the Governor of the State of Maryland, selected from a list submitted by the Medical and Chirurgical Faculty of the State of Maryland, such list having been composed from a list of nominees submitted by Component Societies of the Medical and Chirurgical Faculty and two other licensed practicing physicians of the State of Maryland appointed by the Governor of the State of Maryland.

(c) Three members of the Board of Medical Examiners to be selected by the Board of Medical Examiners.

(d) The Chairman of the Council of the Medical and Chirurgical Faculty of the State of Maryland.

2) Members. Seven of the nine members of the Commission are a quorum for the transaction of all business.

The Commission may establish and maintain an office within this State and shall make, adopt and promulgate rules and regulations for its own government and for the proper supervision and control of the professional conduct of all persons under its jurisdiction, as provided herein and not inconsistent with the laws of this State or of the United States.

There shall always be nine members and no person shall serve in a dual capacity. If there are

nominations which would lead to such an occurrence, the Governor may designate a practicing physician from a list submitted by the Medical and Chirurgical Faculty of the State of Maryland, such a list having been composed from a list of nominees submitted by Component Societies of the Medical and Chirurgical Faculty.

3) Terms of Office. The terms of office for each appointee shall be for three years or until his successor is duly elected or appointed and qualified. Terms of office shall be from the first of July each year, except when the initial appointments are made, and there shall be three persons for one year, three persons for two years, and three persons for three years.

4) Reports. The Commission shall make annual reports to the Governor, the Board of Medical Examiners, and the Medical and Chirurgical Faculty of the State of Maryland.

5) Removal of members. Any member of the Commission may be removed by the Governor for neglect of duty, misconduct, or malfeasance or misfeasance in office.

6) Compensation. Members of the Commission shall receive no salary but may be reimbursed for actual expenses incurred in connection with their official duties with the Commission.

7) Procedure. The Commission shall refer any cases coming to its attention to the appropriate local county society or Committee of the Medical and Chirurgical Faculty of the State of Maryland, for investigation and report. The report shall be acted upon within 90 days unless there is a time extension granted by the Commission. The report shall contain such recommendations as the investigation reveals might be necessary for adequate disciplinary procedures. The recommendations will then be considered by the Commission, which will take whatever action it deems appropriate, as provided herein. All such investigations, reports and recommendations shall be considered confidential until such time as a final action is taken by the Commission.

   The Medical and Chirurgical Faculty of the State of Maryland may initiate action by virtue of information coming to its attention from its own members or through any other source, such cases being handled in the same manner as though they had been referred to it by the Commission.

8) Powers. When the Commission has completed its investigation according to the process outlined herein, it shall have the power to reprimand a physician or place him on probation, revoke or suspend his license, or dismiss the charges against any licensed physician for any of the causes listed below as unprofessional conduct:

   (a) Fraudulent or deceptive procuring or use of a license.
   (b) Solicitation or advertising contrary to Section 13 of this Act.
   (c) The performance of an abortion, contrary to Section 15 of this Act.
   (d) Conviction of a crime involving moral turpitude.
   (e) Abandonment of a patient.
   (f) Addiction to narcotics, habitual drunkenness or rendering professional services to a patient if the physician is intoxicated or under the influence of drugs.
   (g) Promotion by a physician of the sale of drugs, devices, appliances or goods provided for a patient in such a manner as to exploit the patient for financial gain of the physician.
   (h) Immoral conduct of a physician in his practice as a physician.
   (i) Willfully making and filing false reports or records, in his practice as a physician.
   (j) Willful omission to file or record, or willfully impeding or obstructing a filing or recording, or inducing another person to omit to file or record medical reports required by law.
   (k) Failure to furnish details of a patient's medical record to succeeding physicians or hospitals upon proper request.
   (l) Solicitation of professional patronage by agents or persons, or profiting from the acts of those representing themselves to be agents of the licensed physician.
   (m) Division of fees or agreeing to split or divide the fees received for professional services with any person for bringing to or referring a patient
   (n) Willful misrepresentation in treatments.
   (o) Practicing medicine with an unlicensed physician except in an accredited preceptorship or residency training program; or aiding or abetting such unlicensed persons in the practice of medicine.
   (p) Gross and willful and continued overcharging for professional services; including filing of false statements for collection of fees for which services are not rendered.
   (q) Offering, undertaking or agreeing to cure or treat disease by a secret method, procedure, treatment or medicine.
   (r) Professional or mental incompetency.

9) Subpoena. The Commission may issue subpoenas and administer oaths in connection with any investigation, hearing or proceeding under this section.

10) Hearing and attorney rights. Any physician who has a case referred to the Commission on medical discipline shall have the right to appear in person before the Commission at a hearing duly convened to consider said case, at which time he may be represented by counsel; all proceedings of the Commission shall be subject to the provisions of the Administrative Procedures Act in Article 41 of this Code.

11) Certificate of revocation or suspension—Reprimand. If a majority of the members of the Commission find the accused guilty of unprofessional conduct as specified in the charges, the Commission shall prepare written finding of fact and may thereafter prepare and file in the office of the Board of Medical

Examiners a certificate or order of revocation, suspension, or reprimand, in which case notice thereof shall be served upon the accused forthwith.

12) Dismissal of charges—Exoneration. If the license holder is found not guilty, the Commission shall forthwith order a dismissal of the charges and the exoneration of the accused, and no further action may be taken by the Commission on the charges involved. After such finding of not guilty, the Commission shall expunge all records.

13) Revocation or suspension of license—Stay pending review. The filing by the Commission in the office of the Board of Medical Examiners of a certificate or order of revocation or suspension, after due notice, hearing and findings in accordance with the procedure specified in this section, certifying that any holder of a license has been found guilty of unprofessional conduct by the Commission shall constitute a revocation or suspension of the license to practice medicine and surgery in this State in accordance with the terms and conditions imposed by the Commission and embodied in the certificate or order of revocation or suspension. If the licensee seeks judicial review of the Commission's decision pursuant to the provisions of this section, such revocation or the period of such suspension shall be stayed and shall not be effective or commence to run until final judgment has been entered in any proceeding instituted under the provisions of this section and the licensee's judicial remedies exhausted hereunder.

14) Contents of certificate—Recording. The certificate or order of revocation or suspension shall contain a brief and concise statement of the ground or grounds upon which the certificate or order is based and the specific terms and conditions of such revocation or suspension, and shall be retained as a permanent record by the Board of Medical Examiners as well as by the Commission.

15) Issuance of license after revocation or suspension. The Board of Medical Examiners shall not issue any license or any renewal thereof to any person whose license has been revoked or suspended by the Commission except in conformity with the terms and conditions of the certificate or the order of revocation or suspension, or in conformity with any order or reinstatement issued by the Commission or in accordance with the final judgment in any proceeding for review.

16) Appeal from decision by Commission. Any person whose license has been revoked or suspended by the Commission, or any person placed on probation under this section, may have a judicial review of the Commission's decision. He may enter any appeal to the Supreme Bench of Baltimore City or in the Circuit Court in the County in which the charges originated or in which the physician maintains his principal office and serve notice of said appeal on the Commission within 30 days after the filing of the certificate or of the revocation, suspension, probation or reprimand.

Section 12. **Advertising.**

No physician shall advertise except as provided by regulations of the Board.

Anatomical Gift Act

Section 13. **Legislative intent.**

Because of the rapid medical progress in the field of tissue and organ preservation, the transplantation of tissue, and tissue culture, and because it is in the public interest to aid the development of this field of medicine, it is the policy and purpose of the General Assembly of Maryland in enacting this Act to encourage and aid the development of reconstructive medicine and surgery and the development of medical research by facilitating pre-mortem and post-mortem authorizations for donations of tissue and organs. It is the purpose of this Act to regulate only the gift of a body or parts of a body to be made after the death of a donor.

Section 13A. **Definitions.**

1) Person. Means individual, corporation, government or governmental agency or subdivision, estate, trust, partnership or association, or any other legal entity.

2) Body or part of body. Includes organs, tissues, bones, blood and other body fluids, and "part" includes "parts".

3) Licensed hospital. Includes any hospital licensed by the State Board of Health and Mental Hygiene under the laws of this State, and any hospital operated by the United States government, although not required to be licensed under the laws of the State of Maryland.

4) Licensed physician or surgeon. Means any physician or surgeon licensed to practice under the laws of this State.

Section 13B. **Persons who may execute an anatomical gift.**

1) Any individual who is over the age of twenty-one (21) years of age and who is competent to execute a will may give all or any part of his body for any one or more of the purposes specified in this Act, the gift to take effect after death.

2) Unless he has knowledge that contrary directions have been given by the decedent, the following persons, in the order of priority stated, may give all or any part of a decedent's body for any one or more of the purposes specified in this Act:

(a) the spouse, if one survives;
(b) an adult son or daughter;
(c) either parent;
(d) an adult brother or sister;
(e) the guardian of the person of the decedent at the time of his death;
(f) any other person or agency authorized or under obligation to dispose of the body.

If there is no surviving spouse and an adult son or daughter is not immediately available at the time of death of a decedent, the gift may be made by either parent. If a parent of decedent is not immediately available, the gift may be made by any

adult brother or sister of decedent. But, if there is known to be a controversy within the class of persons first entitled to make the gift, the gift shall not be accepted. The persons authorized by this subsection to make the gift may execute the document of gift either after death, or during a terminal illness. The decedent may be a minor or a stillborn infant.

3) If the gift is made by a person designated in Section 13B. 2) of this Act, it shall be by written or telegraphic consent.

Section 13C. **Persons who may become donees, and purposes for which anatomical gifts may be made.**

The following persons are eligible to receive gifts of human bodies or parts thereof for the purposes stated:

1) Any licensed hospital, surgeon or physician; for medical education, research, advancement of medical science, therapy, or transplantation to individuals.

2) Any accredited medical school, college, or university engaged in medical education or research; for therapy, educational research, or medical science purposes.

3) Any person operating a bank or storage facility for blood, arteries, eyes, pituitaries, or other human parts; for use in medical education, research, therapy, or transplantation to individuals.

4) Any specified donee; for therapy or transplantation needed by him.

Section 13D. **Manner of executing anatomical gifts.**

1) A gift of all or part of the body for purposes of this Act may be made by will, in which case the gift becomes effective immediately upon death of the testator without waiting for probate. If the will is not probated, or if it is declared invalid for testamentary purposes, the gift, to the extent that it has been acted upon in good faith, is nevertheless valid and effective.

2) A gift of all or part of the body for purposes of this Act may also be made by document other than a will. The document must be signed by the donor in the presence of two witnesses, who, in turn, shall sign the document in the donor's presence. If the donor cannot sign in person, the document may be signed for him, at his direction and in his presence, and in the presence of two witnesses, who, in turn, shall sign the document in the donor's presence. Delivery of the document or gift during the donor's lifetime is not necessary to make the gift valid. The document may consist of a properly executed card carried on the donor's person or in his effects. The document and/or card shall conform substantially to the following form:

"Certificate of Authorization for Post-Mortem Study and Examination or Removal of Tissues or Organs

I, the undersigned, this ---------- day of ----------, 19------, desiring that my ---------- be made available after my demise for:

A. Any licensed hospital, surgeon or physician; for medical education, research, advancement of medical science, therapy or transplantation to individuals;

B. Any accredited medical school, college or university engaged in medical education or research; for therapy, educational, research or medical science purposes;

C. Any person operating a bank or storage facility for blood, arteries, eyes, pituitaries, or other human parts, for use in medical education, research, therapy or transplantation to individuals;

D. The donee specified below, for therapy or transplantation needed by him or her; do hereby donate my ---------- for said purpose to

---------- ----------

(Name of Person) (Address)

I hereby authorize a licensed physician or surgeon or the State Anatomy Board to remove and preserve for use my ---------- for said purpose.

Witnessed this ---------- day of ----------, 19------ ----------

(Donor)

---------- ----------

(Name and Address) (Address)

---------- ----------

(Name and Address) (Telephone)

The gift becomes effective immediately after the death of the donor.

3) The gift may be made either to a named donee, or without the naming of a donee. If the latter, the gift may be accepted by and utilized at the discretion of the attending physician at or following death. If the gift is made to a named donee who is not readily available at the time and place of death, and if the gift is evidenced by a properly executed card or other document carried on the donor's person, or in his effects, the attending physician at or following death may, in reliance upon the card or other document, accept and utilize the gift in his discretion, as the agent of the donee. The agent possesses and may exercise all of the rights and is entitled to all of the immunities of the donee under this Act.

4) The donor may designate in his will or other document of gift the surgeon, physician, or technician to carry out the appropriate procedures. In the event of the non-availability of such designee, or in the absence of a designation, the donee or other person authorized to accept the gift may employ or authorize any licensed surgeon, licensed physician, or technician for the purpose.

5) A document of gift executed in another state and in accord with the laws of that state thereunto pertaining or executed in a territory or possession of the United States under the control and dominion of the federal government exclusively, and in accord with a federal law thereunto pertaining, shall be deemed valid as a document of gift within the State of Maryland, notwithstanding that the said document does not substantially conform to the requirements of Section 13D. 2) of this Act.

Section 13E. **Delivery to donee.**

If the gift is made to a named donee, the will or other document or an attested true copy thereof may be delivered to him, to expedite the appropriate procedure, immediately after death; but such delivery is not necessary for validity of the gift. Upon request of the named donee or his agent on or after the donor's death, the person in possession shall produce, for examination, the will or other document of gift.

Section 13F. **Revocation of gift.**

1) Any document of gift which has been delivered to the donee may be revoked by either—
   (a) the execution and delivery to the donee or his agent of a revocation in writing, signed by the donor, or
   (b) an oral statement of revocation witnessed by two persons, and communicated to the donee or his agent, or
   (c) a statement during a terminal illness addressed to the attending physician and communicated to the donee, or his agent, or
   (d) a card or other writing signed by the donor and carried on his person or in his effects, revoking the gift.

2) Any document of gift which has not been delivered to the donee may be revoked in the manner set out in subsection 1) of this section, or by destruction, cancellation, or mutilation of the document.

3) Any gift made by a will may be revoked in the manner set out in subsection 1) of this section, or in the manner provided for revocation or amendment of wills.

Section 13G. **Effect of gift on rights of donee.**

1) The donee may accept or reject the gift. When the gift is only a part of the body, promptly following the removal of the part named, custody of the remaining parts of the body shall be transferred to the next of kin, or other person or agency authorized or under obligation to dispose of the body. The time of death shall be determined by the physician in attendance upon the donor's terminal illness or certifying his death, and said physician shall not be a member of the team of physicians which transplants the part to another individual.

2) A person who, in good faith and acting in reliance upon and authorization made under the provisions of this Act and without notice of revocation thereof, takes possession of, performs surgical operations upon, or removes tissue, substances, or parts from the human body; or refuses such a gift; or any person who unknowingly fails to carry out the wishes of the donor according to the provisions of this Act, shall not be liable for damages in a civil action brought against him for such act.

3) The provisions of this Act are subject to the laws of this State prescribing powers and duties with respect to autopsies and are not in contravention thereof.

Section 13H. **Effect of gift during lifetime of donor.**

The provisions of this Act shall not apply to gifts of parts of the body when said gifts are made during the lifetime of the donor with the intention that the said part of the body be delivered to the donee during the lifetime of the donor.

Section 13I. **Severability.**

If any provision of this Act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the Act which can be given effect without the invalid provisions or applications, and to this end the provisions of this Act are declared to be severable. If any section, paragraph, clause or sentence of this Act shall, for any reason, be adjudged by any court of competent jurisdiction to be unconstitutional and invalid, such judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the section, paragraph, clause, or sentence thereof so found to be unconstitutional and invalid.

Section 13J. **Prior authority or instrument.**

Nothing in this Act shall invalidate any authority or instrument executed prior to July 1, 1968.

Section 13K. **Short title.**

This Act may be cited as the Anatomical Gift Act.

Section 14. **Consent of minors.**

1) The consent of the provision of medical or surgical care or services by a hospital, public clinic, or the performance of medical or surgical care or services by a physician, licensed to practice medicine, when executed by a minor who is, or professes to be married, or by a female minor who is or professes to be pregnant, or by a minor who is or professes to be afflicted with a venereal disease, shall be valid and binding as if the said minor had achieved his or her majority as the case may be; that is, a minor who is, or professes to be married, or a female minor who is, or professes to be pregnant, or a minor who is, or professes to be afflicted with a venereal disease, shall be deemed to have, and shall have the same legal capacity to act, and the same legal obligations with regard to the giving of such consent to such hospital or clinical care or services or medical or surgical care or services to be provided by a physician licensed to practice medicine, as a person of full legal age and capacity, the infancy of the said minor and any contrary provisions of law notwithstanding, and such consent shall not be subject to later disaffirmance by reason of such minority; and the consent of no other person or persons (including, but not limited to a spouse, parent, custodian, or guardian) shall be necessary in order to authorize such hospital or clinical care or services or medical or surgical care or services to be provided by a physician licensed to practice medicine to such a minor or minor's child.

2) Upon the advice and direction of a treating physician or if more than one, any one of them, member of the medical staff of a hospital, public clinic, or physician licensed to practice medicine may, but shall not be obligated to, inform the spouse, parent, custodian or guardian of any such minor in the circumstances as enumerated in sub-section (a)

hereof, as to the treatment given or needed, and such information may be given to, or withheld from the spouse, parent, custodian or guardian without the consent of the minor patient and even over the express refusal of the minor patient providing such information; the providing or withholding of such information to rest in the sole discretion of a member of the medical staff of the hospital, public clinic or the physician licensed to practice medicine, as the case may be. In the event that the said minor is found not to be pregnant or not afflicted with a venereal disease, then no information with respect to any appointment, examination, test or other medical procedure shall be given to the spouse, parent, custodian or guardian of said minor.

3) The provisions of this Section shall also apply to minors who profess to be in need of hospital or clinical care or services or medical or surgical care or services to be provided by a physician licensed to practice medicine, whether because of suspected pregnancy or venereal disease, regardless of whether such professed suspicions of pregnancy or venereal disease are, or are not subsequently substantiated on a medical basis.

4) Any consent given pursuant to the provisions of this Section by a minor shall not be deemed to be valid if, following a delivery or other termination of a pregnancy, it is determined that surgery not directly connected with the pregnancy is required or shall be requested.

Section 15. **Abortion.**

(A) A physician licensed by the state of Maryland may terminate a human pregnancy or aid or assist or attempt a termination of a human pregnancy if said termination takes place in an accredited hospital and that one or more of the following conditions exist:

(1) There is substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother;

(2) Continuation of the pregnancy is likely to result in the death of the mother;

(3) There is substantial risk of the birth of a child with grave and permanent physical deformity or mental retardation;

(4) That the pregnancy resulted from a rape committed as a result of force or bodily harm or threat of force or bodily harm, and less than sixteen weeks of gestation have passed and that the State's Attorney of Baltimore City or the County in which the alleged rape has occurred has informed the physician in writing over his signature that there is probable cause to believe that the alleged violation did occur.

(B) An annual report of the therapeutic abortions performed in Maryland shall be made by the director of the hospital and its governing board to the Joint Commission on Accreditation of Hospitals and the State Board of Health and Mental Hygiene for the purpose of insuring that adequate and proper procedures are being followed in accredited hospitals. Said reports shall be considered confidential information and will come under the provisions of Article 43, Section 20 of the Medical Practice Act.

Section 16. **Abortion—Refusal to participate.**

A person who is an employee, a member, or associated with the staff of a hospital (as defined in Section 556 of this Article) in which a human pregnancy is being terminated, and who states in writing, on moral or religious grounds, an objection to the termination of human pregnancy, shall not be required to participate in the medical procedures which result in the termination of the pregnancy; and the refusal of that person to participate in these medical procedures shall not be a basis for any disciplinary or other recriminatory action against him.

Section 17. **Abortion—Misdemeanor.**

1) A person is guilty of a misdemeanor if he

(a) sells or gives, or causes to be sold or given, any drug, medicine, preparation, instrument, or device for the purpose of causing, inducing, or obtaining a termination of human pregnancy (other than in such a hospital);

(b) gives advice, counsel, or information for the purpose of causing, inducing, or obtaining a termination of human pregnancy (other than in such a hospital);

(c) knowingly assists or causes by any means whatsoever the obtaining or performing of a termination of human pregnancy (other than in such a hospital);

(d) furnishes or provides a drug or medicinal preparation, by the prescription of a licensed physician, having the purpose of terminating a human pregnancy when taken internally, unless such drug or medicinal preparation is furnished or provided in an accredited hospital.

2) Also, the termination of a human pregnancy by a licensed physician, under emergency conditions at a place other than such a hospital, is specifically not included within the enumeration of misdemeanors in subsection 1) of this section, if the physician shall forthwith report said termination to the director of an accredited hospital in his county, as herein defined.

3) Any person who violates any provision of this section, upon conviction, is subject to a fine of not more than five thousand dollars for each offense, or to imprisonment for not more than three years, or both such fine and imprisonment. The penalties in this section are in addition to and not in substitution for any other penalty or penalties applicable to particular classes of persons under other laws of this State.

4) Nothing in Sections 15, 16 and 17 of this Act applies to, or affects the prosecution or penalty for any event or occurrence prior to July 1, 1968.

Section 18. **Aid at the scene of an accident.**

1) A physician who renders medical aid, care, or assistance not in a hospital, under emergency conditions at or near the scene of an accident or other occurrence for which he charges no fee or compensation shall not be liable for any civil damages as

the result of any professional act or omission by him not amounting to gross negligence.

2) The members of volunteer ambulance and rescue squads shall not be liable for damages as provided in subsection (1) hereof, provided that such members have completed an advanced Red Cross or equivalent course in first aid, and be on duty as members of a volunteer ambulance and rescue squad which (a) is a bona fide and permanent organization and (b) is operated as a nonprofit group.

3) Registered nurses and licensed practical nurses shall have the same immunity from civil damages as are provided in subsection (1) hereof.

Section 19. **Cancer.**

1) No person other than a physician or dentist shall hold himself out as being able to treat, cure, or prescribe treatment for the disease of cancer.

2) No person shall sell, offer to sell, or give away, except on the prescription of a physician or dentist any drug, medicine, compound, nostrum, or device represented by the manufacturer or seller thereof to have curative powers in the treatment of the disease of cancer.

3) "Cancer" as used in this section means all malignant neoplasms regardless of the tissue of origin and includes but is not limited to malignant lymphoma and leukemia.

Section 20. **Confidential Records.**

1) All records, and other information procured by the Faculty, component societies, in-hospital staff committees and national medical societies or groups organized for research which contain the identity of any person are confidential records.

   (a) Access to and use of such confidential records shall be regulated by Section 101 of Article 35 and Section 10 of Article 75C of this Code.

   (b) Nothing in this section shall restrict publication of statistics and data which do not disclose the identity of any person.

2) All proceedings and transactions before the Faculty and records thereof pertaining to the investigation and report by the Faculty pursuant to Section 11 of this Act shall be confidential to the extent provided for by subsection (1) hereof.

Section 21. **Criminal Penalties.**

1) A person shall be guilty of a misdemeanor upon conviction of the following and shall be fined not less than one hundred dollars nor more than five thousand dollars, or imprisoned for not less than one year nor more than five years, or both:

   (a) The registration as a physician with the Board when such person is not a physician; or,

   (b) The presentation of any false information to the Board; or,

   (c) The practice of medicine contrary to Section 4 of this Act; or,

   (d) The treatment of cancer contrary to Section 19 of this Act.

2) A person shall be guilty of a misdemeanor upon conviction of the following and shall be fined not less than twenty-five dollars nor more than five hundred dollars:

   (a) The failure to register as required by Section 10; or,

   (b) Violating any of the provisions of Section 20.

Section 22. **Title.**

This act shall be known as the "Medical Practice Act."

Section 23. **Severability.**

Should any provision or application of this Act be held invalid, such invalidity shall not affect the other provisions or applications, and to this end the provisions of this Act are declared to be severable.

AMERICAN MEDICAL ASSOCIATION EDUCATION AND RESEARCH FOUNDATION COMMITTEE

This Committee was abolished at the Semiannual Meeting, 1967.

THE AMERICAN RED CROSS BLOOD RESEARCH PROGRAM

Background on the Research Program

The American Red Cross has long been active in research and development in the preparation of new plasma protein fractions and the preservation of red cells and blood platelets. Acutely aware of the necessity for its Blood Program to offer the most advanced and complete transfusion service to the American people, the organization is seeking to develop procedures that will bring the highest yield of the best quality of all components of blood at a per unit cost that will be economically practical.

Blood contains many components—red cells, plasma proteins, white cells and platelets. Each of these is essential to the human organism. During illness the administration of the element lacking in a patient's blood may restore him to health. This is the basis of component therapy. It enables the physician to give his patient only the part of blood that he needs. As the medical uses for blood increase, it is necessary to make the widest possible use of the blood received from each individual donor. Through component therapy, the unit of blood given by one donor may be used for many patients.

The new research laboratory in Bethesda makes possible a very broad-based research and development program specifically oriented toward solving the complex and interrelated problems of blood component therapy. An expanded staff of scientists and technicians is employing new and sophisticated equipment in an effort to push back the horizons of blood knowledge and learn even more about the components of blood and how they may be adapted for use in treating human ills.

The Red Cross recently received a contract for more than $1,000,000 from the National Institutes of Health (National Heart Institute) to develop a workable system of large-scale fractionation of whole blood into a series of cellular and protein elements.

The national medical director of the Red Cross Blood Program is Dr. Tibor J. Greenwalt. The research program is directed by Dr. James H. Pert. His associate director is Dr. Alan J. Johnson, who heads the Red Cross Blood Research Laboratory at New York University-

Bellvue Hospital in New York. Dr. Johnson's assistant in New York is Dr. Marjorie B. Zucker, and Dr. Pert's assistant director in the Bethesda laboratory is Dr. Graham A. Jamieson.

The American Red Cross Blood Program is the largest single blood collection and distributing service in the world. It operates through a system of 57 blood centers established through the joint efforts of the Red Cross, the medical profession, the hospitals and the people they serve. Some 1,700 Red Cross chapters assist in the collection of blood from volunteer donors in areas of the country where over 114 million Americans live. An average of three million units of blood, given through the Red Cross each year, are provided to civilian and government hospitals.

Using the best procedures now available, the Red Cross is providing hospitals with whole blood, packed red cells, platelet concentrates, fresh frozen plasma, cryoprecipitates, and the plasma protein derivatives albumin, gamma globulin and fibrinogen. With the rapid advances in science and technology it is clear that substantial improvement over past methods can be made and vitally needed new derivatives can be prepared from the blood presently being collected.

The safe and efficient separation of blood components and their preservation for long periods are among the chief targets of the new laboratory. Following is a list of current research projects:

Red Blood Cell Preservation

The long range goal of the red cell freezing project is to develop a method for long-term preservation that is economical enough for large scale use, simple enough to be performed by technicians without highly specialized training, and flexible enough to meet the varying needs of routine blood banking as well as those of war and disasters. Considerable progress toward this end has already been achieved. The loss of cells from the freezing process is usually less than 3 percent, most of which is mechanical rather than the result of cell injury. In nearly fifty transfusions of frozen processed red cells given to seriously ill patients, we have consistently found a good clinical response and no undesirable reactions. After transfusion, the cells appear to circulate the same or nearly the same as fresh cells.

One of the immediate objectives of the project is to test out the hardware required for wider clinical application. Another is to reduce the cost; to this latter end, the cost of consumable supplies has already been decreased to less than $15 a unit. We are working with a number of laboratories to solve the problem of simplifying the post-thaw washing process which now requires careful and time-consuming re-sterilization of equipment or, as with batch-washing, takes too long (1½ hours) and causes too great a loss of blood.

Facilities for large scale freezing are being rapidly established at the Bethesda laboratory. The first three liquid nitrogen storage boxes, (25 cubic feet each), are in operation with supporting equipment for blood processing and will provide storage for over 2,000 units of frozen blood. Rare bloods are currently being collected by the regional centers, shipped here and frozen for storage in these liquid-nitrogen refrigerators.

During the past year the superiority of the American Red Cross low-glycerol rapid-freeze procedure has been recognized, and it is being investigated by a number of laboratories in this country and overseas. We are now working closely with the United States Navy blood-freezing laboratory, exchanging our latest modifications of equipment and supplies to adapt the process to a large scale program for military purposes.

The useful applications for civilian use of frozen processed red cells are receiving careful attention. Plans for testing in artificial kidneys have been developed. These patients require treatment for six hours twice a week; it will therefore be possible to obtain precisely timed samples and careful long-term follow-ups. It must be determined whether or not the pumping system of the artificial kidney injures the frozen cells. The successful progression of these studies will lead to the testing of frozen cells in open heart surgery and a determination of whether the washing process may reduce the high incidence of hepatitis which now occurs after heart surgery. This work will be carried out in conjunction with the National Institutes of Health blood bank, and blood is already frozen and stored for this purpose.

Blood Platelets

Platelets are microscopic cell fragments which normally circulate in the blood and prevent blood loss by plugging injured blood vessels. In good health we have over 300,000 platelets in every cubic millimeter of blood, but in leukemia, radiation injury and other diseases, the count may fall below 20,000, even to 5,000 and serious bleeding may occur in any part of the body. A normal function of platelets is to form clumps and assist in clotting, during which process they are destroyed. Because of their extreme fragility, it is important to use great care and special techniques in preparing concentrates which will be in optimal condition for transfusion. An additional consideration is that platelets rapidly lose viability when removed from the body and must be transfused within hours after collection—their present "shelf life" is 6-12 hours. Low temperature preservation appears to be the only practical answer to extending this and making routine treatment practical.

The principal method for improving the quality of platelet concentrates employs the addition of acid, but this, unfortunately, is injurious to some plasma proteins. We have developed an acidification process which provides the best platelet preparation without injury to the plasma. More recently we improved upon this procedure by eliminating the need for acidification through controlling the temperature of the concentrate after plasma removal. Clinical testing of this method, now in process, is very promising. These improvements have been possible because the level of platelet function can now be measured during serotonin release and enzyme release.

Further understanding of the biochemistry and physiology of platelets provided the bases for these advances. Other potentially greater improvements based upon competitive inhibition of ADP-induced clumping are now under study.

With improvement in the quality of platelet concentrates, greater emphasis has been placed on preservation by freezing. In addition to studying new methods, we have modified an existing procedure so that it can be used on a large scale. The clinical results indicate improvement over other freezing methods but more important is the increase in value—already we have frozen as many as 180 platelet concentrates in one day. Inexpensive freezing containers proved feasible, and the need for a complex controlled-rate freezer was eliminated. Four-to-eight hundred frozen concentrates are now kept on hand and have proved effective in emergency situations on weekends and holidays, when fresh blood supplies may be low. Since over 80 percent of Red Cross blood is collected by mobile units, we are also studying procedures

of platelet freezing which can be used in mobile laboratories.

The National Cancer Institute of the National Institutes of Health has played a major role in platelet research and demonstrations of the clinical value of platelet transfusions.

Fractionation

Plasma, the fluid portion of blood, transports all of the nutrients needed throughout the body. In addition to red cells, white cells and platelets, the plasma carries a large number of proteins, each with specific functions. Some general categories of these proteins are enzymes, hormones, immunoglobulins (prevent infection), blood-clotting factors, fibrinolytic factors (dissolving blood clots), metalloproteins (iron transport), etc. Classic plasma fractionation provides only three for routine clinical therapy, albumin, gamma globulin and fibrinogen. These useful blood products can be fractionated in higher yield and purity by newer laboratory methods. We are adapting these methods for large scale processing with the objective of obtaining a better quality and yield at a lower cost. New fractionation techniques are being developed for preparing some of the other proteins for which there is the greatest need.

AHF: Outstanding success has been obtained with the purification of antihemophilic factor (AHF). An intermediate purity preparation will soon be licensed and a high purity AHF is now being used experimentally in the treatment of severe bleeding conditions in patients with hemophilia who would otherwise require large quantities of fresh blood and plasma. Both preparations are far superior in yield, purity and stability to any AHF preparation ever produced. In fact, it seems technically possible that a hemophilic will be able to carry with him a vial the size of a fountain pen containing a full therapeutic dose of the high-potency AHF. If cost can be sufficiently reduced, treatment would be similar to the use of insulin. The director of the Red Cross Research Laboratory in New York, Dr. Alan Johnson, is primarily responsible for this breakthrough.

Clotting Factors II, VII, IX, and X: Now that the major objectives have been achieved in the preparation of AHF, (Factor VIII), research efforts are being directed at fractionating a preparation containing Factors II, VII, IX, and X. This concentrate of clotting proteins will be used to prevent bleeding in patients lacking one or more of these factors, as occurs in liver diseases, Christmas disease, etc.

Standards: Again, new fractionation methods are being used to prepare highly purified, stable reference standards; these are clotting factors, clot-dissolving factors and immunoglobulins. Proper "yard sticks" are not yet available in this field, for there are no established quantitative units uniformly used by all laboratories. We therefore need standards for reproducible quality control and for correct comparison of our results with those of other laboratories. Sufficient progress has been made that many of these preparations are now being adopted by the National Institutes of Health and the World Health Organization as the official or working standards in this country and throughout the world.

Detecting Agents of Hepatitis

The transmission of hepatitis by blood and its components is a major problem. During the past year a transferrable substance has been found in the blood and serum of patients ill with infectious hepatitis that suppresses mitosis and causes chromosomal anomalies. This phenomena is now being studied further in order to determine what this factor is and to develop a simple technique of determining its presence so that it can be used in mass screening for hepatitis in blood banks.

To help carry out these principal objectives of the program, laboratories in the following specialized fields have been set up to aid the researchers:

Assay Laboratory

Although the ultimate test for any blood component must be its effectiveness in the patient, it is obviously more practical to have laboratory tests to evaluate the effectiveness of various components during their preparation. In the assay laboratory, a variety of biological tests are used to determine changes in the red cell and platelets during preparation or freezing. The measurement of enzyme has been found particularly valuable in the past year in improving the method of preparing platelets.

Biophysics

The Biophysics Section of the research laboratory is a core facility which provides specialized information and assistance to the other research sections. The radioisotope unit carries out such tests as the determination of red cell survival and platelet function with C^{14} serotonin release. We are linked by telephone with a large computer, and data from diverse laboratory projects are processed and analyzed. One study of particular importance to the work on low temperature preservation of red cells and platelets is performed with a differential thermal analyzer, an instrument which measures changes in the structure of ice crystals at sub-freezing temperatures. Test results will indicate whether certain temperatures should be avoided during long-term storage or shipping of frozen cells.

Biochemistry

The Biochemistry Section provides information and assistance to research projects being pursued in other areas of the laboratory. Sensitive and highly specialized methods of biochemical analysis are used for the measurement of particular components of proteins and for their separation and identification on a minute scale.

A number of studies are also being carried out to relate the function and structure of proteins. Certain plant extracts which have possible value in blood typing have been purified; components of the surface of the platelet, which is important in blood coagulation, are being characterized and experiments are being carried out on the genetic variants of certain proteins which occur in the plasma of normal blood donors.

Electrophoresis

One of the most useful techniques for separating and identifying proteins is electrophoresis, the separation of proteins in an electrical field. By this means, it is possible to separate many of the components present in blood plasma, to determine their purity after fractionation, and with the specialized equipment, to determine the actual amounts present in the serum of different individuals.

Fabrication

A broad study has been carried out to evaluate the effect of cryogenic temperatures (down to —320° F) on various plastics and other materials used in the freezing of blood components. Teflon has been the most useful plastic for low temperature preservation and, in collaboration with various industries, a machine has been developed which is now in operation for making freezing

containers for red cells and platelets processed in the blood research laboratory. The wide range of new and improved plastics now available are being screened for possible use in blood transfusion. Some of these plastics hold the promise of being more effective for blood component separation and less expensive than present materials.

The new Red Cross Research and Development Laboratory is housed in a modern, three-story brick building located at 9312 Old Georgetown Road, Bethesda, Maryland. Originally designed for a physicians' office building, it contains 21,000 square feet of floor space, more than five times the space occupied by the laboratory previously located at national headquarters in Washington. A branch of this laboratory is operating at New York University-Bellvue Hospital in New York.

The Bethesda Building contains numerous laboratory workrooms, including cold rooms and freezers necessary to protect blood components from room temperatures during the fractionation process. Also installed in the laboratory are instruments and equipment of the most up to date and sophisticated types.

RECAP OF WHOLE BLOOD INVENTORY FISCAL YEAR 1966/67

	Fiscal Year 1966/1967		*Fiscal Year 1965/66*	
Inventory on hand, July 1		315		218
Collections: Unit I	23,413		21,373	
Unit II	5,239		4,019	
Unit III	3,942		3,234	
TOTAL		32,594		28,626
Received from other centers		1,014		3,052
Total Available		33,923		31,896
Returns from Hospitals		228		177
Total		34,151		32,073
Other Sources		23		24
TOTAL		34,174		32,097
Distribution:				
To Civilian Hospitals	23,546		23,120	
To Federal Institutions	4,117		4,740	
To Hospitals Outside Region	2		48	
To Blood Banks (Non ARC)	69		40	
To Regional Blood Centers	1,208		61	
Sub-Total	28,942		28,009	
Fresh Blood Into Plasma	4,697		3,486	
Outdated Blood Into Plasma	0		21	
Broken	0		0	
Other (Research, etc.)	255		266	
Total Distribution		33,894		31,782
Inventory on Hand June 30		280		315

COLLECTIONS: 1966/67

	Scheduled	*Presenting*	*Collected*
Unit I	32,441	31,716	23,413
Unit II	8,258	7,263	5,239
Unit III	8,760	4,447	3,942
TOTAL	49,459	43,426	32,594

COLLECTIONS: 1965/66

Unit I	21,788	30,936	21,373
Unit II	6,237	5,693	4,019
Unit III	5,727	3,991	3,234
TOTAL	33,752	40,620	28,626*

Representatives on the Medical Advisory Committee of the Red Cross Blood Bank Program: Everett S. Diggs, MD, C. Thomas Flotte, MD, Carroll L. Spurling, MD, Gerald A. Galvin, MD.

* Including 92 Department of Defense Donations

BOARD OF MEDICAL EXAMINERS

Mr. President and Members of the House of Delegates:

The annual report, which I am submitting, will begin with a statistical summary.

Examinations given during the year show the following results:

Applications received for examination		580
Second year students examined and reexamined	71	
Postponed, withdrawn or did not appear	78	
Failed to complete	2	
Not eligible for examination for license		151
Examined in second part of examination	108	
Complete examination	238	
Reexamined	83	
Eligible for license		429
Passed—American Graduates	156	
Passed—Foreign Graduates	171	
Failed—American Graduates	14	
Failed—Foreign Graduates	88	
Licenses issued after examination	327	
Licenses issued by endorsement or by reciprocity of other state licenses	148	
Licenses issued by endorsement of National Board Certificates	264	
Total licenses issued by endorsement or Reciprocity		412
Total licenses issued by endorsement, Reciprocity, and examination		739
Licenses revoked	2	
Licenses suspended	1	
Licentiates certified to other states	263	
Copies of licenses issued	16	
American graduates examined and reexamined	170	
Foreign graduates examined and reexamined	261	
Foreign graduates approved for examination	189	
Written inquiries from foreign graduates (approximately)	700	
Office interviews with foreign graduates (approximately)	400	
Telephone inquiries from foreign graduates (approximately) (Increased, due to reciprocity)	1,800	
Telephone inquiries concerning registration of physicians	1,200	
1966-69 Registration certificates issued to 12/31/66	8,380	
1966-69 Registration certificates issued from 1/1/67 to 12/31/67	1,368	
Total 1966-69 Registration certificates issued to 12/31/67		9,748
Reciprocity granted to foreign graduates	10	

Licensed by Special Examination

Jose M. Quintero, MD	—December 16, 1966
Callum Roy Bain, MD	—January 20, 1967
Peter Serafino Scoles, MD	—January 20, 1967
George S. D'A. Bailey, MD	—February 17, 1967
Charmian Elkes, MD	—February 17, 1967
Roy P. Lindgren, MD	—May 19, 1967
John T. Craighead, MD	—November 17, 1967
Pedro A. Inglesias, MD	—November 17, 1967
Winifred M. Ross, MD	—November 17, 1967

Chairs for Examination Hall

250 tablet arm chairs were purchased for use in the Examination Hall in July, 1967.

Application for Restoration of License

Webster Sewell, MD made application for restoration of his Maryland medical license. The Secretary was instructed to inform Dr. Sewell that his license remains revoked.

Probation

Carlos Arrabal, MD appeared before the Executive Committee on January 31, 1967, April 14, 1967, and July 21, 1967, and gave a satisfactory report of his activities.

Yuen K. Yuan, MD, appeared before the Executive Committee on March 17, 1967 and June 9, 1967. The Executive Committee, on October 5, 1967, released Dr. Yuan from future appearances at its meetings and closed the case.

Elizabeth Reese Wilkens, MD was placed on probation for an FDA violation, with instructions to appear quarterly at Executive Committee meetings, for a term to correspond with the court probation.

Violation of Narcotics Code

Matthew M. Cox, MD was found guilty of narcotic violations, and his Maryland medical license was revoked on April 20, 1967.

Clay Henry Johnson, MD, was charged with a narcotic violation and placed on probation, subject to the continuance of his probation by the Board of Medical Examiners of Louisiana, further action of this Board being contingent upon the action of the Boards of Louisiana and Texas.

Abortion

Jesse Williams II, MD was convicted of the crime of manslaughter in New York State and given a hearing in Maryland, at which he was not present. It was decided that the Maryland medical license of Dr. Jesse Williams II, be revoked.

James F. McCarter, MD and Stuart A. Perkal, MD were charged with conspiring to cause an abortion and causing an abortion, with plea of nolo contendere. After reviewing the case, no factual evidence was at hand for discipline by the Board.

Unethical Solicitation of Business

William H. Philpott, MD was charged with solicitation of business in an unethical and illegal manner. The matter was turned over to the Attorney General.

Cases Reported to the Board

Conspicuous signs, practicing of medicine without a license, Clinical Psychologists practicing medicine, use of drugs by podiatrists, Medical Eye Clinic operated by an Optician, and piercing of ears by Chain Store jewelers. All of the above cases have been settled by the State's Attorney. Two of them are being evaluated by the Attorney General's Office. Other cases are—forged signatures on prescriptions by out-of-state physicians licensed in Maryland, and failure of physicians to cooperate with insurance companies.

Suspension of license by other states

There was one such suspension.

Falsifying of application blanks

One such case came before the Board.

Request for license due to suspension of license in another state

There was one request.

Income Tax Evasion

There was one doctor charged with tax evasion, with a plea of nolo contendere. He was reprimanded by the Board.

Laboratories advertising violation

There was one violation of this law.

Cases Pending

There are four cases pending.

Reorganization of Board

Due to the death of Secretary-Treasurer, Frank K. Morris, MD, the following officers were elected:

President—Vernon H. Norwood, MD
Vice President—Karl F. Mech, MD
Secretary-Treasurer—Walter C. Merkel, MD

Sixty-Third Annual Congress of Medical Education and Licensure

Doctors Walter C. Merkel, Vernon H. Norwood, and Frank K. Morris, representing the Board, attended the Congress held in Chicago.

Foreign Reciprocity

The General Assembly withheld a bill within the House Judiciary committee which would have seriously affected the Board's selection of candidiates for reciprocity. In view of this withholding, all of the members of the Board indicated that the discrepancies between the District of Columbia Board and Maryland be settled by a compromise. Your Board immediately changed the status concerning reciprocity where foreign graduates are involved. As of June, 1967, Maryland will accept applicants by reciprocity and endorsement after licensure in any other state or the District of Columbia after having been licensed and in reputable practice for a period of five years.

Internships and Residencies

The Board adopted a regulation whereby internship and residency training in bordering states will be accepted in lieu of the Maryland training.

Osteopaths

The change in the Medical Practice Act as of June 1, 1967, will now recognize Osteopaths who have graduated from an approved osteopathic school since 1940, possess a DO Degree, and have one year hospital training in a recognized institution, as being eligible for licensure.

Respectfully submitted,

WALTER C. MERKEL, MD, *Secretary*
VERNON H. NORWOOD, MD
KARL F. MECH, MD
GERALD A. GALVIN, MD
JOHN H. HORNBAKER, MD
WILBER R. ELLIS, MD
ELMER G. LINHARDT, MD
WILLIAM L. STEWART, MD

BYLAWS COMMITTEE REPORT

Mr. President and Members of the House of Delegates:

The Bylaws Committee recommends the following changes in the Bylaws:

Explanation: Because of the rapid growth of Montgomery and Prince Georges Counties, as well as the total Active, Emeritus and Forty-year members in the Central District, it is necessary to realign the representation of the Councilors so as to provide a more equitable distribution.

Amend Article IV, Section 1, by striking out the figure "17" and substituting the figure "22".

OLD

(Underlined and bracketed portions to be struck out)

Section 1. The Elective Officers shall be a President a President-Elect, a First, Second and Third Vice-President, a Secretary, a Treasurer and (17) Councilors.

NEW

(Underlined portion to be inserted)

Section 1. The Elective Officers shall be a President, a President-Elect, a First, Second and Third Vice-President, a Secretary, a Treasurer and 22 Councilors.

Amend Article IV, Section 3 (c) by substituting the following new section:

"Central District: Baltimore City, Baltimore and Harford Counties; eleven councilors including at least eight from Baltimore City, two from Baltimore County and one at large."

OLD

(Underlined and bracketed portions to be struck out)

(c) Central District: Baltimore City, Baltimore and Harford Counties; (nine councilors including at least seven from Baltimore City, one from Baltimore County and one at large.)

NEW

(CAPS portion to be added.)

(c) Central District: Baltimore City, Baltimore and Harford Counties; ELEVEN COUNCILORS INCLUDING AT LEAST EIGHT FROM BALTIMORE CITY, TWO FROM BALTIMORE COUNTY AND ONE AT LARGE.

Amend Article IV, Section 3 (e) by substituting the following new section:

"South Central District: Montgomery and Prince Georges Counties, five councilors including at least three from Montgomery County."

OLD	*NEW*
(Underlined and bracketed portions to be struck out)	(CAPS portion to be added.)
(e) South Central District: Montgomery and Prince Georges Counties; (two councilors.)	(e) South Central District: Montgomery and Prince Georges Counties; FIVE COUNCILORS, THREE FROM MONTGOMERY COUNTY, AND TWO FROM PRINCE GEORGES COUNTY.

Explanation: Under the proposed Commission on Medical Discipline, the Immediate Past-President, the President, the President-elect and the Council Chairman would serve by virtue of their office on this Commission. In order that these officers not serve as judge and jury both, it is necessary that they be deleted from the committee membership as shown.

Amend Article XI, Section 11, by striking out the words "The Chairman of the Council and not more" and inserting the words, "not serving on the Commission on Medical Discipline and at least".

OLD	*NEW*
(Underlined and bracketed portions to be struck out)	(CAPS portion to be added.)
Section 11. A Mediation Committee composed of the five most recent living Immediate Past Presidents, (the Chairman of the Council and not more) than five additional members appointed by the President shall hear and determine all grievances or complaints involving or growing out of the practice of medicine as provided by these bylaws and mediate all problems involving or growing out of the practice of medicine. The chairman shall be appointed by the President. The Baltimore City Dental Society shall have the right to elect one associate member of the committee with voice but without vote in all committee deliberations except those relating to grievances or complaints.	Section 11. A Mediation Committee composed of the five most recent living Immediate Past Presidents NOT SERVING ON THE COMMISSION ON MEDICAL DISCIPLINE AND AT LEAST five additional members appointed by the President shall hear and determine all grievances or complaints involving or growing out of the practice of medicine as provided by these bylaws and mediate all problems involving or growing out of the practice of medicine. The chairman shall be appointed by the President. The Baltimore City Dental Society shall have the right to elect one associate member of the committee with voice but without vote in all committee deliberations except those relating to grievances or complaints.

Amend Article XI, Section 25, by adding the following: "and the Mediation Committee."

OLD	*NEW*
	(CAPS portion to be added.)
Section 25. The President, President-elect and Secretary shall be ex officio members of all committees except the Nominating Committee.	Section 25. The President, President-elect and Secretary shall be ex officio members of all committees except the Nominating Committee AND THE MEDIATION COMMITTEE.

Explanation: In order to make it abundantly clear that the Faculty shall refer all Mediation cases coming to its attention to local components for action the following bylaw amendment is submitted:

Amend Article XIII, Section 1 (3) by striking out the words "against a member by a member" and substituting the words, "against a physician by a physician."

OLD	*NEW*
(Underlined and bracketed portions to be struck out)	(CAPS portion to be added.)
Section 1. Grievances (1) affecting the practice of medicine in the entire State or more than one County thereof; (2) against the Faculty by a member or component society or (3) (against a member by a member), a patient or other person, the appropriate component society having declined to hear the grievance, shall be filed in writing with the Mediation Committee.	Section 1. Grievances (1) affecting the practice of medicine in the entire State or more than one County thereof; (2) against the Faculty by a member or component society or (3) AGAINST A PHYSICIAN BY A PHYSICIAN, a patient or other person, the appropriate component society having declined to hear the grievance, shall be filed in writing with the Mediation Committee.

Amend Article XIII, by inserting a Section 2 as follows: "Section 2. Matters referred to the Faculty by the Maryland Commission on Medical Discipline shall be referred to the Mediation Committee for action. The Committee shall, upon receipt of such matters, forward them to the appropriate component society for initial investigation and report to the Committee. The Committee may conduct such further investigation as may be necessary for report to the Commission, said report to contain findings of fact, conclusions of law and recommendations for disciplinary action."

OLD	*NEW*
	(CAPS portion to be added.)
(No old section)	SECTION 2. MATTERS REFERRED TO THE FACULTY BY THE MARYLAND COMMISSION ON MEDICAL DISCIPLINE SHALL BE REFERRED TO THE MEDIATION COMMITTEE FOR ACTION. THE COMMITTEE SHALL UPON RECEIPT OF SUCH MATTERS FORWARD THEM TO THE APPROPRIATE COMPONENT SOCIETY FOR INITIAL INVESTIGATION AND REPORT TO THE COMMITTEE. THE COMMITTEE MAY CONDUCT SUCH INVESTIGATION AS MAY BE NECESSARY FOR REPORT TO THE COMMISSION, SAID REPORT TO CONTAIN FINDINGS OF FACT, CONCLUSIONS OF LAW AND RECOMMENDATIONS FOR DISCIPLINARY ACTION.

Amend Article XIII, Section 3, by striking out, "The Committee's findings and recommendations in the form of resolutions shall be filed with the Council for consideration and action, provided that the Committee may, of its own motion, refer the matter to the Board of Medical Examiners. Any party aggrieved by the action of the Committee," and inserting the following: "The findings and recommendations of the Committee shall be sent to the interested parties. Any party aggrieved by the action of the Committee, except in matters of report to the Commission."

OLD	*NEW*
(Underlined and bracketed portions to be struck out)	(CAPS portion to be added.)
Section 3. (The Committee's findings and recommendations in the form of resolutions shall be filed with the Council for consideration and action, provided that the Committee may, of its own motion, refer the matter to the Board of Medical Examiners. Any party aggrieved by the action of the Committee) may, within 30 days of such action, file an appeal in writing with the Council which shall hear the appeal on the record allowing only such additional evidence as is newly discovered.	Section 3. THE FINDINGS AND RECOMMENDATIONS OF THE COMMITTEE SHALL BE SENT TO THE INTERESTED PARTIES. ANY PARTY AGGRIEVED BY THE ACTION OF THE COMMITTEE, EXCEPT IN MATTERS OF REPORT TO THE COMMISSION, may within 30 days of such action, file an appeal in writing with the Council which shall hear the appeal on the record allowing only such additional evidence as is newly discovered.

Amend Article XIII, Section 4, by inserting at the beginning of the section the words, "Except in matters for report to the Commission,".

OLD	*NEW*
	(CAPS portion to be added.)
Section 4. Appeals filed in writing within 30 days may be taken from any final action by a component society in cases of grievances and shall be heard *de novo* by the Mediation Committee, with the right of further appeal to the Council.	Section 4. EXCEPT IN MATTERS FOR REPORT TO THE COMMISSION, appeals filed in writing within 30 days may be taken from any final action by a component society in cases of grievances and shall be heard *de novo* by the Mediation Committee, with the right of further appeal to the Council.

Explanation: In order to clarify and make it abundantly clear that it is guests of the Faculty and not necessarily guests of the individual members of the Faculty, the following change in Standing Rules of the House is proposed:

Amend Standing Rule #2 of the House of Delegates by striking the words, "their guests" in both paragraphs and substituting the words, "guests of the Faculty"

OLD	*NEW*
(Underlined and bracketed portions to be struck out)	(CAPS portion to be added.)
Meetings of the House of Delegates shall be attended only by members of the House, members of the Faculty and (their guests) and such members of the staff as may be necessary. The privileges of the floor at meetings of the House of Delegates shall be extended to members of the Faculty who are not Delegates, to (their guests) and to such members of the staff as may be necessary. Seating on a	Meetings of the House of Delegates shall be attended only by members of the House, members of the Faculty and GUESTS OF THE FACULTY, and such members of the staff as may be necessary. The privileges of the floor at meetings of the House of Delegates shall be extended to members of the Faculty who are not Delegates, to GUESTS OF THE FACULTY and to such members of the staff as may be

portion of the floor shall be reserved for them at all meetings of the House of Delegates. Non-members of the House may, at the request of a Delegate, be extended the privilege of debating a pending motion by a three-fourths vote.

necessary. Seating on a portion of the floor shall be reserved for them at all meetings of the House of Delegates. Non-members of the House may, at the request of a Delegate, be extended the privilege of debating a pending motion by a three-fourths vote.

The Bylaws Committee also considered placing a limitation on the terms of the Board of Medical Examiners members. After considerable discussion it was concluded that no such proposal should be made at this time. This is for the information of the House.

(Supplemental Report)

Mr. President and Members of the House of Delegates:

Following the formal meeting of the Bylaws Committee, the Montgomery County Medical Society submitted two proposed Bylaw changes. These are now offered to the House of Delegates as submitted by that component society *without endorsement or comment.* The House of Delegates should direct the Bylaws Committee as to its feelings in this matter so that bylaw changes can be prepared for submission to the Semiannual session, if that is the desire of the House.

The Proposals

"Every Component Society having at least 15% representation of the total active membership in the State Society shall have at least one member on every standing Committee of the State Society, including the Executive Committee"

Analysis of the committee assignments for the 1967-68 year, indicates that the Montgomery County Medical Society is represented on all Faculty Committees except two: the Occupational Health Committee and the Public Relations Committee. Under normal circumstances, the Faculty president endeavors to give representation as far as possible and provided there are members willing to serve, to the major components of the Faculty on all Committees. In the same year that Montgomery County had one or more representatives on 14 out of 16 committees, 3 of the Faculty's 16 committee chairmen were from Montgomery County.

The other amendment from Montgomery County read as follows:

"The Nominating Committee shall include one member *annually* from Montgomery County Medical Society"

For eight years, Montgomery County has had members on the Nominating Committee five times. Prince George's County the other three times, as one member in accordance with our By-laws must be from one or the other component.

The Bylaws Committee wishes an expression from the House on these two proposals from Montgomery County.

Respectfully submitted,

Charles F. O'Donnell, MD, *Chairman*
Robert vL. Campbell, MD
Arthur T. Keefe, MD
Edmond J. McDonnell, MD

COMMITTEE ON CONTRACTUAL ARRANGEMENTS

Mr. President and Members of the House of Delegates:

During the past year, the Committee has held only two formal meetings, both of which involved final arrangements with respect to the separation of billing for radiology and pathology services between hospitals and physicians. In some cases, this resulted in the hospital billing for the technical aspects of these services and physicians billing for professional services. In other cases, physicians assumed responsibility for the total service. To date, we have not heard of any insurmountable difficulties in this transition.

In addition to the formal meetings, we have been consulted on numerous occasions with respect to individual contracts into which physicians planned to enter with groups, hospitals, or others. These contracts have been examined as to the ethics involved and to their legality as seen from the medical profession. In all instances, satisfactory arrangements with the parties involved were completed.

Respectfully submitted,

Belden R. Reap, MD, LLB, *Chairman*
Robert Z. Berry, MD
Stanley J. Bociek, MD
Leonard J. Gallant, MD
Paul F. Guerin, MD
Theodore R. Kardash, MD
John G. Lyons, MD
William J. McClafferty, MD
Elliott Michelson, MD
William A. Niermann, MD
Thaddeus E. Prout, MD
Guy M. Reeser, MD
Albert Shapiro, MD
Charles E. Silverstein, MD
James W. Smyth, MD
Henry B. Wilson, MD
Henry Startzman, MD

CURATOR

Mr. President and Members of the House of Delegates:

During the past year we have continued with the work of restoration of the various oil portraits throughout the Faculty Building. In 1967 five more portraits were restored and put into good condition. As authorized by the House of Delegates several years ago, this is an annual appropriation and continues from year to year without annual approval.

During the year, we added the following items to our collection of memorabilia:

Framed photograph of Lewis Henry Steiner, MD, a gift from his grandson, Richard L. Steiner.

Instruments and other surgical material property of Augustus Clewell, MD, as a gift of Clewell Howell, MD.

These items were formally acknowledged and the appreciation of the Faculty expressed to the donors.

Respectfully submitted,

E. David Weinberg, MD, *Curator*

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Mr. President and Members of the House of Delegates:

All three delegates and the three alternate delegates attended the clinical meeting of the American Medical Association held in Houston, Texas, November 26-29, 1967.

The following is a report of the actions taken at this meeting. Full details or additional information may be obtained from either the Faculty office or through any of your delegates.

There was no lack of positive action in the Houston meeting, at which 238 out of 242 Delegates (98.3%) attended the final two sessions, dealing with 96 items of business, including 17 reports from the Board of Trustees; 20 from the four Standing Committees of the House; one special report each from the AMA-ERF and the Commission to Coordinate the Relationships of Medicine With Allied Health Professions and Services; and 57 resolutions from state medical societies or individual physicians.

Of those, the House adopted 43 without amendment; amended and adopted 22; referred 21; absorbed four into other adopted items; and rejected six.

Distinguished Service Award

Owen H. Wangensteen, MD, director of the Department of Surgery at University Hospitals, Minneapolis, was named the winner of the 1968 Distinguished Service Award. The award will be presented to Dr. Wangensteen at the Annual Convention in San Francisco in June, 1968.

AMA-ERF Institute for Biomedical Research

In a special report on the AMA Education and Research Foundation, Charles L. Hudson, MD, Immediate Past President of the AMA and President of the AMA-ERF, reported to the House that the Board of Directors of the AMA-ERF had "voted to endorse in principle the relocation of the Institute for Biomedical Research on, or contiguous to, the University of Chicago campus, and authorized the Executive Vice President, with appropriate other members of staff and the President and Secretary-Treasurer of the Foundation to negotiate a contract with the University of Chicago for consideration by the Board of Directors of the AMA-ERF." This action was approved by the House of Delegates.

At the same time, the House requested the Board of the AMA-ERF "to present at each Clinical Convention a report on the projected budget of the Institute for Biomedical Research for the ensuing year and the amount of the projected contribution from the American Medical Association to the Institute during that period."

Medical Education

Several actions were taken relating to medical education.

One was adoption of the Board of Trustees' summary of the Report of the Commission on Research. Fifteen recommendations were contained in the Commission report, two of which were seen as particularly significant.

Recommendation 12 encouraged research in the delivery of health care, "provided it is conducted under proper auspices and in accordance with sound research design and methodology." The House adopted it, with the understanding that such support "should not be interpreted to imply any criticism of the present studies of the delivery of health care." Present efforts are productive, but the medical profession "should not hesitate to make known its interest in continued studies to improve the methods and quality of health care delivery."

Recommendation 13 was addressed to correcting the imbalance between biomedical research and education caused by the "heavy but desirable federal support of research." It stated that "there should be allotted a greatly increased amount for operational expenses of medical schools, to be matched by those schools through private or local governmental sources."

Again the House concurred, stressing the fact that its approval of the recommendation changes the policy of the AMA with respect to federal support for medical education. The change results in "an honest recognition that federal financial support is *now* accepted by the American medical schools." However, in adopting the recommendation, the House "emphatically urges that a matching formula be used" to "encourage medical schools to retain their independence."

The House also adopted a resolution that the AMA, through its Council on Medical Education, "utilize all appropriate influences to restore teaching to its proper place of prominence in medical education" instead of giving the lion's share of attention, honors and contributions to research scientists; and adopted 12 guidelines for medical staffs in hospitals with intern and resident training programs.

Health Manpower

A report was adopted on the "Report of the National Advisory Commission on Health Manpower," which was submitted to President Johnson on November 20.

The report was necessarily brief, since there had not been time to study and evaluate the Commission report in any depth, but it pointed out that the Commission's approach to health care problems indicated recognition of the need for orderly procedures rather than harmful "crash" programs. The emphasis in most of the Commission report is to center responsibility on the professional groups best able to evaluate and plan in health areas, rather than on government and non-professionals.

The House adopted the preliminary report; voted to enlarge the AMA Committee on Health Manpower by four members to permit more careful and complete study in this area; and noted that copies of the complete Commission report will be sent to all Delegates and Alternates, requesting them to submit their comments to their constituent associations as soon as possible.

In addition, the House approved replacing the present AMA Commission to Coordinate the Relationships of Medicine With Allied Health Professions and Services with a new council of the Board of Trustees to be known as the Council on Allied Health Professions; and directed the Association to seek the establishment of a medically oriented federal Commission on Health Resources and Medical Manpower to assure properly balanced distribution of health personnel among government agencies, the armed forces and the civilian population.

Also with respect to health personnel, both professional and allied, the House asked that a report be made at the next meeting evaluating the foreign resident, intern and physician program; requested a study of the present professional liability implications in the use of allied medical personnel; and urged physicians to become acquainted with the programs of the American Association of Medical Assistants and to encourage their assistants to participate in its educational and certification programs.

Health Care

The House adopted a number of reports and resolutions relating to health care from the standpoint of the community and the individual patient.

One emphasizes that standards of medical care are set at the local level and calls attention to disturbing trends pointing to the possible establishment of medical care standards on a national basis.

Another commits the AMA to leadership in informing the public, the profession and other elements of the health care field as to practical means of moderating health care costs, the value of voluntary health insurance, expanding the medical manpower supply and improving the health care of the American people.

With respect to comprehensive planning of health facilities and services, the House urged state and local medical societies to emphasize a variety of activities to be undertaken in the area of over-all planning for governmental and private programs of health care, including "Continued effort by the medical profession to improve federal legislation in this area and to emphasize the importance of local control."

The House reaffirmed that the procurement, processing, distribution or use of human blood and other human tissue is a medical service and is not the selling of a commodity. The Board of Trustees and the state associations were urged to support legislative action at federal and state levels to implement this concept.

The use of monitoring, defibrillation and resuscitative equipment by registered nurses in cases of cardiac emergencies was supported, with provisions regarding the nurse's training and the procedures established by the hospital medical staff.

Alcoholism was identified as a complex disease and the House recognized that the medical components of this entity are medicine's responsibility.

Medicare and Medicaid

In regard to medicare, the House reaffirmed its support for direct billing under the federal program and adopted a resolution regarding the collection and public dissemination of figures on the administrative costs of medicare.

The House resolved that the AMA continue its efforts to provide for the implementation of Title 19 in a manner which recognizes "the physician's right to bill directly all patients, including Title 19 patients, and allows the physician or his patient to be reimbursed his usual, customary and reasonable fee for his professional services;" and that the Association actively seek changes in the law that will secure "equal and simultaneous application to all jurisdictions."

Other Legislative Matters

A resolution urging continuing opposition to S-2299, (the Long drug bill) and a report detailing the current status of HR-12080, (Social Security Amendments of 1967) were adopted.

The House also adopted recommendations that the AMA arrange a meeting of state medical association representatives to plan regional conferences of physicians to discuss matters of special interest to state legislators; and that state associations invite key lawmakers to attend these AMA conferences.

Also approved was a resolution that state associations establish active legislative task forces at the congressional district level to maintain an effective working relationship with congressmen.

Support for AMPAC was reaffirmed in a resolution that requested the Board of Trustees to seek additional ways of helping AMPAC enlarge its activities and its assistance to state medical political action committees.

Hospitals

Because both medicare and medicaid provide payment for medical care rendered to patients by residents, the House resolved that the Association should study the problem and develop guidelines that are acceptable to supervising physicians, teaching institutions and government agencies involved in the payment process.

In addition, with respect to hospitals, the House adopted resolutions:

—Proposing the acceptance of physicians on hospital Boards of Trustees as the most effective form of liaison between the medical staff and hospital governing authorities.

—Protecting hospital privileges through "due process."

—Calling for more effective liaison and better coordination between medical staffs and local medical societies.

—Pointing out the need for simplifying attendance requirements for maintaining membership on hospital medical staffs.

—Pressing for prompt revision of the JCAH ruling on the use of externs in non-university affiliated hospitals, with the incorporation of adequate safeguards to insure the quality of programs of extern education.

In addition, model articles of incorporation for hospital medical staffs were made available for distribution in response to requests.

AMA Organization and Procedures

A number of changes were made in the Bylaws:

—Chapter XIV, Section 3(D) was updated, providing that four trustees will be elected annually, each for a three-year term and each limited to three terms.

—The terms in office of the President, President-Elect and Vice President all will begin and end at the close of the final session of the House of Delegates at the Annual Convention.

—Resolutions must be introduced to the House by a voting delegate.

—Nominations for Affiliate Membership in the AMA in classes (3), (4), (5) and (6) must be approved by the appropriate county and state medical society.

—A general officer's position is to be considered vacant if he misses six consecutive regular meetings of the Board.

—The House approved giving the Vice President voting rights on the Board.

Convention Sites

Sites and dates for future conventions will be:

Annual

1968	San Francisco, June 16-20
1969	New York, July 13-17
1970	Chicago, June 21-25
1971	Atlantic City, June 20-24
1972	San Francisco, June 18-22
1973	New York, July 15-19
1974	Chicago, June 16-20

Clinical

1968	Miami Beach, December 1-4
1969	Denver, Nov. 30-Dec. 3
1970	Boston, Nov. 29-Dec. 2
1971	New Orleans, Nov. 28-Dec. 1
1972	Atlanta, November 26-29
1973	Anaheim, Cal., November 25-28
1974	Portland, Ore., December 1-4

AMA Objectives

The House adopted a statement of 11 purposes and responsibilities for the AMA, designed to define more clearly the over-all purpose as written in the Constitution: "To promote the science and art of medicine and the betterment of public health."

The entire statement follows:

The Purposes and Responsibilities
of the American Medical Association

It is the responsibility of the American Medical Association, as the representative of the American medical profession, to continue to foster the advancement of medical science and the health of the American people.

Its continuing purposes are to meet this responsibility through the following means:

1. By encouraging the further development of medical knowledge, skills, techniques and drugs; and by maintaining the highest standards of practice and health care.

2. By creating incentives to attract increasing numbers of capable people into medicine and the other health-care professions.

3. By advancing and expanding the education of physicians and other groups in the health-care field.

4. By motivating skilled physicians who have the art of teaching to apply themselves to developing new generations of excellent practitioners.

5. By fostering programs that will encourage medical and health personnel to serve voluntarily in the areas of need for medical care.

6. By developing techniques and practices that will moderate the costs of good medical and health care.

7. By seeking out and fostering means of making all health-care facilities—physicians' offices, hospitals, laboratories, clinics and others—as efficient and economical as good medical practice and attention to human values will permit.

8. By combining the utilization of the latest knowledge for prevention and treatment with the vital healing force of the physician's personal knowledge of and devotion to his patient.

9. By maintaining the impetus of dedicated men and women in providing excellent health care by preserving the incentives and effectiveness of unshackled medical practice.

10. By maintaining the highest level of ethics and professional standards among all members of the medical profession.

11. By continuing to provide leadership and guidance to the medical profession of the world in meeting the health needs of changing populations.

Additional Actions

A memorial to Percy E. Hopkins, MD, was read to the House and a copy was sent to Dr. Hopkin's widow. Dr. Hopkins served as a Trustee for seven years, the last four as its Chairman. He also served for eight years as a Delegate from Illinois.

The House reiterated its serious concern with respect to the Blue Cross Association's request for government funds for its research project on group practice.

Criteria for the evaluation of medical programs of national voluntary health agencies were adopted.

Three resolutions, referred to the Board, pointed out that many news stories criticizing the rising cost of health care place all or most of the responsibility squarely on physicians. As one of the resolutions put it, "Statistical reports relating to health care costs are misleading when they are referred to . . . as medical care costs; and . . . the improper labeling . . . may actually delay proper analysis of the several components."

The American Medical Association urged medical society officers and executives to participate in the activities of their Blue Shield Plans and opposed action removing approval of Blue Shield Plans by a sponsoring medical society.

The AMA asked that all plans "be and continue to serve as economic arms of the medical profession in offering sound alternatives to the public in the voluntary financing of health care."

Respectfully submitted,
Robert vL. Campbell, MD
J. Sheldon Eastland, MD
Russell S. Fisher, MD

COMMITTEE ON EMOTIONAL HEALTH

Mr. President and Members of the House of Delegates:

The Committee on Emotional Health has devoted much of its discussions during the past year to study plans whereby the general practitioner or other non-psychiatric physicians could participate in educational programs so as to treat patients with psychiatric disturbances, particularly those who are discharged from mental hospitals and have returned to their family physician.

The Maryland Academy of General Practice is working with the Faculty's Committee on Emotional Health in formulating educational outlines for psychiatric training programs for general practitioners, using funds available from various sources such as the National Institutes of Mental Health and the Baltimore Psychoanalytical Society.

A Subcommittee on Drug Abuse was appointed, chaired by Albert A. Kurland, MD. The Subcommittee reviewed the Drug Abuse Control Act coming before the 1968 State Legislature, introduced through the Advisory Council on Preventive Medicine, along with other pertinent information. Plans for future activities include formulation of an educational program for physicians and the public on the treatment of drug addicts.

The Committee on Emotional Health requests the House of Delegates to make the following recommendation to the State Board of Health and Mental Hygiene:

Since the abuse of drugs, especially narcotics, is a continuing social problem which contributes significantly toward crime in our communities, it is hereby resolved that a high priority be given to the establishment of a drug abuse center for Maryland. The functions of this center would be: (1) to provide a seven-day-a-week consultation service for anyone with a drug problem who makes application; (2) to function as a referral agency to appropriate treatment facilities for such applicants; (3) to provide information service on the subject of drug abuse for physicians as well as the public; and (4) in conjunction with these services maintain a laboratory facility utilizing the most advanced techniques for performing daily urine analyses for the use of city and state agencies, as well as hospitals and physicians, both public and private, who wish to utilize this type of resource in the management of their patients.

The problem of lack of emergency admission facilities for acutely emotionally disturbed children came before the Committee. It was suggested that although this is a psychiatric problem, the pediatricians should become involved by encouraging admittance of emotionally disturbed children to general hospitals. The problem was termed "extremely urgent" in view of the public's militancy over it. Further study of facilities and programs presently available in Maryland is to be made.

Non-membership in the Medical and Chirurgical Faculty by about one-third of the members of the Maryland

Psychiatric Society has made it necessary for the Faculty, under its regulations, to charge the Society for the use of meeting facilities at the Faculty building. Some active campaign to urge members of the Psychiatric Society to join the Faculty will be encouraged.

As in previous years much legislation concerning mental health was introduced in the 1968 State Legislature. All of the bills were studied by the Committee and appropriate action taken.

Respectfully submitted,

THURMAN MOTT, JR., MD, *Chairman*
IRVIN H. COHEN, MD
AUGUSTO J. ESQUIBEL, MD
IRENE L. HITCHMAN, MD
VIRGINIA HUFFER, MD
EXALL L. KIMBRO, JR., MD
ALBERT A. KURLAND, MD
JOHN LERTORA, MD
WILLIAM J. PEEPLES, MD
RICHARD H. PEMBROKE, JR., MD
JOSEPH J. REIDY, MD
ISADORE TUERK, MD

SUBCOMMITTEE ON DRUG ABUSE: Albert A. Kurland, MD, Chairman, William E. Abramson, MD, Emmett P. Davis, MD, James D. Drinkard, MD, Stephen A. Hirsch, MD, Addison Pope, MD, Julian W. Reed, MD.

FINANCE COMMITTEE

Mr. President and Members of the House of Delegates:

The Finance Committee concerns itself primarily with the investment portfolio of the special dedicated funds of the Faculty.

In May 1967, the investment portfolio was increased significantly by the addition of the Steiner Fund securities. These securities, valued at $378,000, have been placed under the management of T. Rowe Price together with the other investments of the Faculty.

The entire portfolio, as of December 31, 1967, was reviewed by the committee with the investment counselor. It was a detailed review in which each security was examined to determine its value to the portfolio. A summary of the portfolio at December 31, 1967, showed the market value of invested capital at $954,800, the income for the year was $32,266, and the yield on invested capital for 1967 was 3.8%. The Faculty's experience in 1967 was favorable when compared to other endowment funds.

The committee has recommended, on advice of the investment counselor, that the Coggins Building Fund monies now in an account at Loyola Federal Savings & Loan be invested in securities. The Coggins Fund investments will be segregated from the other securities, but will be managed by T. Rowe Price.

Respectfully submitted,
KARL F. MECH, MD, *Chairman*
M. MCKENDREE BOYER, MD
E. W. DITTO, JR., MD
LOUIS J. KOLODNER, MD
W. KENNETH MANSFIELD, MD

1967 FINANCIAL REPORT

March 22, 1968

CERTIFICATE

The Medical and Chirurgical Faculty
of the State of Maryland,
1211 Cathedral Street,
Baltimore, Maryland. 21201

Gentlemen:

We have made an audit of the records of the Treasurer of The Medical and Chirurgical Faculty of the State of Maryland for the year ended December 31, 1967. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures that we considered necessary in the circumstances.

In our opinion, the balance sheet, together with the supporting statements, present fairly the financial position of the Faculty as of December 31, 1967 and the results from operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

WOODEN, BENSON & WALTON

BALANCE SHEET—DECEMBER 31, 1967

EXHIBIT A

ASSETS

General Fund

Cash

Maryland National Bank			
Regular Checking		85,364.81	
Payroll		1,511.78	
Savings Account		226,345.94	
Petty Cash Funds		400.00	313,622.53
Accounts Receivable			
Membership dues, journal subscriptions, etc.		17,751.55	
Due from other funds			
Med-Chi Insurance Trust Fund	2,873.65		
Educational Fund	374.47		
Immunization Fund	34.20		
Steiner Fund	743.79	4,026.11	21,777.66
Loan Receivable			
Plant Fund			30,000.00
Deferred Charges			
Air Travel		425.00	
Annual Meetings		400.00	
Insurance Premiums		1,795.09	2,620.09
Total General Fund Assets			368,020.28
Endowment and Other Special Funds			
Consolidated Fund—Exhibit A-1			267,267.50
Funded Reserve—Exhibit A-2			16,167.68
Harvey G. Beck—Lectureship Fund—Exhibit A-3			3,156.10
Jesse C. Coggins—Lectureship Fund			
Cash—Maryland National Bank		5,296.91	
New Building Fund—Exhibit A-4		166,956.62	172,253.53
George M. Boyer—Lectureship Fund			
Cash—Loyola Federal Savings and Loan Association			5,214.40
Amos Koontz Memorial Fund—Exhibit A-5			2,665.96
Educational Fund—Exhibit A-6			67,200.19
Medical Annals Fund			
Cash—Union Trust Company of Maryland			1,279.99
Henry P. Laughlin—Special Award Fund			
Cash—Loyola Federal Savings and Loan Association			828.99

LIABILITIES AND CAPITAL

General Fund

Liabilities

Accounts payable		
Trade	9,591.90	
American Medical Association—dues collected	60,750.00	
County Medical Association	18,880.25	
Employee	9.01	
Educational Fund	55,000.00	
Plant Fund	5,635.00	149,866.16
Payroll taxes		
Withholding		
United States—December, 1967	477.69	
State of Maryland—fourth quarter, 1967	1,759.70	
Old Age Benefit—December, 1967	825.96	
Unemployment Insurance		
United States—1967	367.89	
State of Maryland—fourth quarter, 1967	28.93	3,460.17
Designated Fund—library accounts—books and journals		2,772.61
Deferred Income—1968 dues		72,268.50
Surplus—Exhibit C		139,652.84
Total General Fund—Liabilities and Capital		368,020.28
Endowment and Other Special Funds		
Consolidated Fund—Exhibit A-1		267,267.50
Funded Reserve—Exhibit A-2		16,167.68
Harvey G. Beck—Lectureship Fund—Exhibit A-3		3,156.10
Jesse C. Coggins		
Lectureship Fund—Exhibit J	5,296.91	
New Building Fund—Exhibit A-4	166,956.62	172,253.53
George M. Boyer—Lectureship Fund—capital		5,214.40
Amos Koontz Memorial Fund—Exhibit A-5		2,665.96
Educational Fund—Exhibit A-6		67,200.19

Hundley Memorial Lecture in Gynecology			
Cash—Loyola Federal Savings and Loan Association			6,203.87
Lewis H. Steiner Fund—Exhibit A-7			400,032.30
Immunization Fund			
Cash—Loyola Federal Savings and Loan Association			5,295.41
Total Endowment and Other Special Funds			947,565.92

Plant Fund

Cash—Maryland National Bank			124.69
Accounts Receivable—General Fund			5,635.00
Fixed Assets (no depreciation provided)			
1215-1217 Cathedral Street—land—cost		19,118.95	
1209-1215 Cathedral Street			
Land and building—cost	110,635.76		
Improvements—cost	331,525.47	442,161.23	
*Personal Property			
Library books and journals	231,370.00		
Office, library and fixtures	38,336.03		
Antiques and museum pieces	39,013.45		
Portraits	65,000.00	373,719.48	834,999.66
Total Plant Fund Assets			840,759.35

Med-Chi Insurance Trust Fund

Cash—Maryland National Bank—checking			3,981.39
Accounts Receivable			
Subscriber fees needed to pay consulting and legal fees—contra		9,060.00	
Other		662.47	9,722.47
Prepaid insurance premiums			446.67
Total Med-Chi Insurance Trust Fund Assets			14,150.53
Grand Total—All Funds			2,170,496.08

Medical Annals Fund—capital—Exhibit M		1,279.99
Henry P. Laughlin—Special Award Fund—capital		828.99
Hundley Memorial Lecture in Gynecology		6,203.87
Lewis H. Steiner Fund—Exhibit A-7		400,032.30
Immunization Fund		
Due General Fund	34.20	
Capital	5,261.21	5,295.41
Total Endowment and Other Special Funds		947,565.92

Plant Fund

Liabilities		
Jesse C. Coggins—New Building Fund	63,833.02	
Loan Payable—General Fund	30,000.00	93,833.02
Capital—Exhibit O		746,926.33
Total Plant Fund Liabilities and Capital		840,759.35

Med-Chi Insurance Trust Fund

Liabilities	
Edward H. Friend and Company—consulting actuaries	10,373.31
Mercantile-Safe Deposit and Trust Company—legal and consulting fees—contra	9,060.00
Due General Fund	2,873.65
	22,306.96
Deficit—Exhibit P	8,156.43
Total Med-Chi Insurance Trust Fund Liabilities and Capital	14,150.53
Grand Total—All Funds	2,170,496.08

*The appraised value of portraits as of December 31, 1963 was $65,000.00, an increase of $51,000.00 over prior years. All other personal property appraised as of December 31, 1949, with subsequent additions at cost.

STATEMENT OF INCOME, EXPENSES AND TRANSFERS

For Year Ended December 31, 1967

GENERAL FUND

EXHIBIT B

Income

Dues—Baltimore City Dental Society	1,930.00		
—Baltimore City Medical Society	108,262.50		
—Component Societies	111,952.50	222,145.00	
Rents and services			
Baltimore City Medical Society	24,868.00		
Others	6,865.00	31,733.00	
Meetings—annual and semi-annual exhibits		19,851.62	
Journal—advertising	91,101.72		
—subscriptions	1,353.66	92,455.38	
Addressograph service		600.89	
Interest on savings accounts		4,385.60	
Miscellaneous		4,179.62	
		375,351.11	
Transfers from consolidated fund—income for general purposes—Exhibit F		4,449.13	
Total Income and Transfers			379,800.24

Expenses

Accounting fees	1,374.85	
Communications—postage, telephone and telegraph	10,314.39	
Contributions	700.00	
Equipment rental and maintenance	4,577.20	
Fuel	1,902.86	
Gas, electricity and water	4,912.35	
Household and janitorial services	2,024.65	
Insurance—general	2,011.07	
—hospitalization	2,736.59	
Journal expense—printing and commissions	91,369.59	
Legal fees	5,830.20	
Legislative	4,883.24	
Property maintenance	2,769.38	
Meetings—annual and semi-annual	23,317.09	
Office supplies	3,997.71	
Purchases of equipment	7,452.50	
Pension and major medical contribution	12,806.18	
Printing	4,935.60	
Salaries	145,908.89	
Social Security Tax—employer's portion	5,802.35	
Unemployment insurance—United States	367.89	
—State of Maryland	404.59	
Travel	5,771.59	
Supplementary hours	2,536.86	
Library	2,466.57	
Interest—Coggins Fund	5,500.00	
Miscellaneous	5,072.60	
Total Expenses		361,746.79
Excess of income and transfers over expenses—to Exhibit C		18,053.45

STATEMENT OF SURPLUS
For Year Ended December 31, 1967

GENERAL FUND

January 1, 1967—Balance	121,599.39
Addition	
Excess of income and transfers over expenses—for year ended December 31, 1967—Exhibit B	18,053.45
December 31, 1967—Balance—to Exhibit A	139,652.84

EXHIBIT A-1

THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND
Baltimore, Maryland

BALANCE SHEET—DECEMBER 31, 1967
CONSOLIDATED FUND

ASSETS

Income Account			
Cash—The Savings Bank of Baltimore—Exhibit F			
Eugene Cordell Fund	11,663.84		
Special account	21,337.58	33,001.42	
Dividends receivable—Held by Maryland National Bank—Exhibit F		1,747.56	
Investments			
Eugene Cordell Fund—Held by Maryland National Bank—Agent—Exhibit F			
Cash	299.09		
Common stocks	8,598.54	8,897.63	43,646.61
Principal Account			
Held by Maryland National Bank—Agent			
Cash—overdraft		−1,112.08	
Account receivable—Due from Steiner Fund		1,080.77	
Investments—at cost			
Bonds			
United States Government and Municipals	11,483.12		
Other	93,481.65	104,964.77	
Stocks		118,687.43	223,620.89
Total—Income and Principal Account Assets—to Exhibit A			267,267.50

LIABILITIES AND CAPITAL

Income Account		
Liability		
Dues Lewis H. Steiner Fund		
For deposits made to savings account		4,344.17
Capital—Exhibit E		39,302.44
		43,646.61
Principal Account		
Capital—Exhibit G		223,620.89
Total—Income and Principal Accounts—Liability and Capital—to Exhibit A		267,267.50

BALANCE SHEET—DECEMBER 31, 1967
FUNDED RESERVE

Exhibit A-2

ASSETS

Income Account			
Cash—Savings Bank of Baltimore		2,276.32	
Due from principal account—contra		480.34	2,756.66
Principal Account			
Investments—held by Maryland National Bank—Agent			
Cash		178.71	
United States Government Bonds	2,284.38		
Common stocks	10,947.93	13,232.31	13,411.02
Total—Income and Principal Accounts—Assets—to Exhibit A			16,167.68

LIABILITIES AND CAPITAL

Income Account			
Capital—Exhibit H			2,756.66
Principal Account			
Liability			
Due income account—contra		480.30	
Capital—Exhibit H		12,930.68	13,411.02
Total—Income and Principal Accounts—Liability and Capital—to Exhibit A			16,167.68

BALANCE SHEET—DECEMBER 31, 1967
HARVEY G. BECK—LECTURESHIP FUND

Exhibit A-3

ASSETS

Income Account			
Cash—Savings Bank of Baltimore			1,077.00
Principal Account			
Investments—held by Maryland National Bank—Agent			
Cash		109.36	
Common stock		1,969.74	2,079.10
Total—Income and Principal Accounts Assets—to Exhibit A			3,156.10

LIABILITIES AND CAPITAL

Income Account			
Liabilities			None
Capital—Exhibit J			1,077.00
			1,077.00
Principal Account			
Capital—Exhibit J			2,079.10
Total—Income and Principal Accounts Capital—to Exhibit A			3,156.10

BALANCE SHEET—DECEMBER 31, 1967
JESSE C. COGGINS—NEW BUILDING FUND

EXHIBIT A-4

ASSETS

Income Accounts		
Cash—Loyola Federal Savings and Loan Association	64,206.62	
Accrued interest on loan to Plant Fund	750.00	64,956.62
Principal Account		
Accounts receivable		
Due from Plant Fund	63,083.02	
Due from income account—contra	38,916.98	102,000.00
Total—Income and Principal Accounts Assets—to Exhibit A		166,956.62

LIABILITIES AND CAPITAL

Income Account		
Liabilities		
Due to principal account—contra	38,916.98	
Capital (includes $7,154.36 of interest earned during year)	26,039.64	64,956.62
Principal Account		
Capital		102,000.00
Total—Income and Principal Accounts Liability and Capital—to Exhibit A		166,956.62

BALANCE SHEET—DECEMBER 31, 1967
AMOS KOONTZ MEMORIAL FUND

EXHIBIT A-5

ASSETS

Principal Account	
Cash—Loyola Federal Savings and Loan Association	2,665.96
Total Principal Account Assets—to Exhibit A	2,665.96

LIABILITIES AND CAPITAL

Principal Account	
Liabilities	None
Capital—Exhibit K	2,665.96
Total Principal Account Liabilities and Capital—to Exhibit A	2,665.96

BALANCE SHEET—DECEMBER 31, 1967
EDUCATIONAL FUND

EXHIBIT A-6

ASSETS

Principal Account	
Cash—Maryland National Bank—savings account	12,200.19
Account receivable—due from General Fund	55,000.00
Total—Principal Account Assets—to Exhibit A	67,200.19

LIABILITIES AND CAPITAL

Principal Account	
Liabilities	
Due to General Fund	374.47
Capital—Exhibit L	66,825.72
Total—Principal Liabilities and Capital—to Exhibit A	67,200.19

BALANCE SHEET—DECEMBER 31, 1967
LEWIS H. STEINER FUND

Exhibit A-7

ASSETS

Income Account		
Cash—Savings Bank of Baltimore	11,021.41	
Account receivable—due from consolidated fund	4,344.17	
Total Income Account Assets		15,365.58
Principal Account		
Due from income account—contra	5,160.41	
Investments—at book value	379,506.31	
Total Principal Account Assets		384,666.72
Grand Total—Income and Principal Account Assets—to Exhibit A		400,032.30

LIABILITIES AND CAPITAL

Income Account		
Liabilities		
Due to General Fund	743.79	
Due to Principal Account—contra	5,160.41	5,904.20
Capital—Exhibit N		9,461.38
Total Income Account Liabilities and Capital		15,365.58
Principal Account		
Liabilities		
Due to consolidated fund	1,080.77	
Capital—Exhibit N	383,585.95	
Total Principal Account Liabilities and Capital		384,666.72
Grand Total—Income and Principal Account Liabilities and Capital—to Exhibit A		400,032.30

STATEMENT OF INCOME AND EXPENSES
For Year Ended December 31, 1967

Exhibit D

CONSOLIDATED FUND—INCOME ACCOUNT

Income			
Investments—general			
Bonds			
United States Government and municipals	1,181.36		
Others	3,165,43	4,346.79	
Stocks			
Preferred	644.58		
Common	12,286.04	12,930.62	
Interest on special savings account—The Savings Bank of Baltimore		1,120.16	
		18,397.57	
Less—agency fees	1,127.23		
—broker's fees	1,143.15	2,270.38	
Net income—Exhibit F		16,127.19	
Investments—Eugene F. Cordell Fund—Exhibit F			
Stocks			
Common	408.00		
Less—agency fee	24.48	383.52	16,510.71
Interest on savings accounts—The Savings Bank of Baltimore—Exhibit F			492.11
			17,002.82
Expenses—Exhibit F			
Library purposes—general		9,766.63	
General Fund purposes—expenses, maintenance, etc.		4,449.13	
Lectureships		300.00	14,515.76
Excess of Income over Expenses—to Exhibit E			2,487.06

STATEMENT OF CAPITAL
For Year Ended December 31, 1967

Exhibit E

CONSOLIDATED FUND—INCOME ACCOUNT

January 1, 1967—Balance—Exhibit F	36,815.38
Addition	
Excess of income over expenses for year ended December 31, 1967—Exhibit D	2,487.06
December 31, 1967—Balance—to Exhibits A-1 and F	39,302.44

STATEMENT OF RECEIPTS, EXPENSES AND BALANCES
For Year Ended December 31, 1967

EXHIBIT F

CONSOLIDATED FUND—INCOME ACCOUNT

Fund	Distributive Share (Per Cent)	Balance January 1, 1967	Income Received During Year			Balance January 1, 1967 Plus Receipts	Expenses			Balance December 31, 1967	
			Savings Account Interest	Investment Income (Distributive Share)	Investment Income (Direct)		Library	Transferred to General Fund (Exhibit B)	Lectureship	Cash, Investments and Dividends Receivable	Cash on Deposit
Baker	.65	1.13		91.73		92.86	81.50			11.36	
Barker, Lewellys F.	.39	30.41		55.04		85.45	78.63			6.82	
Bowen, Josiah S.	9.17	156.27		1,294.04		1,450.31		1,290.06		160.25	
Bressler, Frank C.	1.80	30.67		254.01		284.68		253.22		31.46	
Cordell, Eugene Fauntleroy	3.64	19,817.08	492.11	513.66	383.52	21,206.37				21,206.37	11,663.84
Cowles, Nellie N.	.75	880.01		105.84		985.85	36.75			949.10	
Ellis, Charles M.	....	....		2,015.51		2,015.51		2,015.51		....	
Finney, John M. T.	8.40	5,957.12		1,185.39		7,142.51	1,044.81		100.00	5,997.70	
Frick, William F.	15.02	255.96		2,119.56		2,375.52	2,113.05			262.47	
Friedenwald, Julius F.	.75	12.78		105.84		118.62		105.51		13.11	
Harlan, Herbert	.76	319.44		107.25		426.69	202.23			224.46	
McCleary, Standish	.75	28.95		105.84		134.79	121.68			13.11	
Osler Endowment	1.40	23.86		197.57		221.43	14.95			206.48	
Osler Testimonial	7.75	3,202.25		1,093.66		4,295.91	489.92	468.30		3,337.69	
Ruhrah, John	40.79	1,718.88		5,756.15		7,475.03	5,397.37			2,077.66	
Stokes, William Royal	3.09	623.52		436.05		1,059.57	137.39		100.00	822.18	
Trimble, Isaac Ridgeway	2.64	3,718.71		372.54		4,091.25	48.35		100.00	3,942.90	
Woods, Hiram	2.25	38.34		317.51		355.85		316.53		39.32	
	100.00	36,815.38	492.11	16,127.19	383.52	53,818.20	9,766.63	4,449.13	300.00	39,302.44	11,663.84
		To Exhibit E	Totals to Exhibit D				Totals to Exhibit D			To Exhibit E	To Summary

SUMMARY—To Exhibit A-1

Cash		
Individual accounts—above	11,663.84	
Special account	21,337.58	
Dividends receivable	1,747.56	34,748.98
Cordell Fund		
Cash	299.09	
Investments	8,598.54	8,897.63
		43,646.61
Less—accounts payable to Steiner Fund		4,344.17
		39,302.44

STATEMENT OF CAPITAL

For Year Ended December 31, 1967

Exhibit G

CONSOLIDATED FUND—PRINCIPAL ACCOUNT

Fund	*Purpose*	*Balance January 1, 1967*	*Net Profit on Security Sales*	*Balance December 31, 1967*
Baker	Books on Materia Medica	1,321.83	81.14	1,402.97
Barker, Lewellys F.	Library	793.11	48.68	841.79
Bowen, Josiah S.	General	18,606.43	1,144,72	19,751.15
Bressler, Frank C.	General	3,651.51	224.70	3,876.21
Cordell, Eugene Fauntleroy	Relief of widows and orphans	7,386.43	454.39	7,840.82
Cowles, Nellie N.	Books on Neurology	1,523.21	93.63	1,616.84
Ellis, Charles M.	General	8,258.46	—	8,258.46
Finney, John M. T.	Books, journals and lectureships on surgery	17,033.52	1,048.60	18,082.12
Frick, William F.	Maintenance of Frick library and purchase of books and journals	30,465.80	1,874.99	32,340.79
Friedenwald, Dr. Julius	Maintenance of Friedenwald room	1,523.22	93.63	1,616.85
Harlan, Herbert	Books on Ophthalmology	1,545.41	94.87	1,640.28
McCleary, Standish	Lectureship and books on Pathology	1,523.22	93.63	1,616.85
Osler Endowment	Permanent endowment for library by request of Dr. Osler	2,835.52	174.77	3,010.29
Osler Testimonial	Medical books and maintenance of Osler Hall	15,717.82	967.46	16,685.28
Ruhrah, John	Library books, journals, etc.	82,745.23	5,091.95	87,837.18
Stokes, William Royal	Lectureship and books on Bacteriology or Pathology	6,275.22	385.74	6,660.96
Trimble, Isaac Ridgeway	Lectureship	5,358.64	329.56	5,688.20
Woods, Hiram	General	4,572.97	280.88	4,853.85
		211,137.55	*12,483.34	*223,620.89
			*Schedule G-1	*To Exhibit A-1

STATEMENT OF SECURITIES SOLD

For Year Ended December 31, 1967

Exhibit G-1

CONSOLIDATED FUND—PRINCIPAL ACCOUNT

Par Value Shares or Rights	*Description*	*Amount Received*	*Cost*	*Profit or —Loss*
	BONDS			
	United States Government			
1,500	Treasury bonds—4%—due October 1, 1969	1,439.06	1,477.50	—38.44
10,000	Treasury bonds—2½%—due December 15, 1972	8,687.50	9,520.37	—832.87
3,500	Treasury bonds—2½%—due December 15, 1972	3,062.50	3,332.13	—269.63
3,000	Treasury bonds—4¼%—due May 15, 1974	2,748.75	3,016.88	—268.13
	Industrial			
2,000	Cities Service Company—3%—due January 1, 1977	1,495.73	2,012.34	—516.61
1,000	Bethlehem Steel Corporation—4.50%—due January 1, 1990	778.49	1,000.00	—221.51
1,000	Michigan Consolidated Gas Company—3.50%—due March 1, 1969	960.99	1,063.00	—102.01
2,000	General Motors Acceptance Corporation—3.50%—due March 15, 1972	1,772.58	2,086.20	—313.62
	Railroad			
500	Wabash Railroad Company—4%—due January 1, 1981	353.51	500.00	—146.49
2,000	Southern Railway Company—5%—due July 1, 1994	1,614.48	2,000.00	—385.52

STOCKS

	Preferred			
42	Crown Cork and Seal, Limited—2% cumulative	1,661.26	1,970.00	—308.74
23	E. I. DuPont de Nemours and Company—$4.50	1,747.10	2,112.00	—364.90
25	Toledo-Edison Company—4¼%	1,557.15	2,487.17	—930.02
13	General Motors Corporation—5%	1,091.49	1,110.00	— 18.51
	Common			
378	United States Fidelity and Guaranty Company	20,979.00	3,990.55	16,988.45
	Stock Rights			
262	Pacific Telephone and Telegraph Company	58.39	—	58.39
200	Continental Oil Company	153.50	—	153.50
		50,161.48	37,678.14	12,483.34
				To Exhibit G

STATEMENT OF CAPITAL
For Year Ended December 31, 1967

EXHIBIT H

FUNDED RESERVE

INCOME ACCOUNT

January 1, 1967—Balance		1,990.69
Additions		
Dividends	671.60	
Interest—United States Government Bonds	62.50	
—Savings Account	75.91	810.01
		2,800.70
Deduction		
Agency fee		44.04
December 31, 1967—Balance—to Exhibit A-2		2,756.66

PRINCIPAL ACCOUNT

January 1, 1967—Balance	12,930.68
No changes during the year	—
December 31, 1967—Balance—to Exhibit A-2	12,930.68

STATEMENT OF CAPITAL
For Year Ended December 31, 1967

EXHIBIT I

HARVEY G. BECK—LECTURESHIP FUND

INCOME ACCOUNT

January 1, 1967—Balance		960.85
Additions		
Dividends	180.40	
Interest—Savings Account	46.59	226.99
		1,187.84
Deductions		
Agency fee	10.84	
Reimbursement to General Fund	100.00	110.84
December 31, 1967—Balance—to Exhibit A-3		1,077.00

PRINCIPAL ACCOUNT

January 1, 1967—Balance	2,079.10
No changes during year ended December 31, 1967	—
December 31, 1967—Balance—to Exhibit A-3	2,079.10

STATEMENT OF CAPITAL
For Year Ended December 31, 1967

EXHIBIT J

JESSE C. GOGGINS—LECTURESHIP FUND

PRINCIPAL ACCOUNT

January 1, 1967—Balance	5,290.21
Addition	
Interest—Savings Account	213.60
	5,503.81
Deduction	
Reimbursement to General Fund	206.90
December 31, 1967—Balance—to Exhibit A	5,296.91

STATEMENT OF CAPITAL
For Year Ended December 31, 1967

EXHIBIT K

AMOS KOONTZ MEMORIAL FUND

PRINCIPAL ACCOUNT

January 1, 1967—Balance	2,549.31
Addition	
Interest on Savings Account	116.65
December 31, 1967—Balance—to Exhibit A-5	2,665.96

STATEMENT OF CAPITAL
For Year Ended December 31, 1967

EXHIBIT L

EDUCATIONAL FUND

PRINCIPAL ACCOUNT

January 1, 1967—Balance		93,662.30
Addition		
Investment Income		4,119.16
		97,781.46
Deductions		
Educational Expenses and Public Relations	3,191.72	
MEDIC Network	16,418.00	
Measles Program	11,346.02	30,955.74
December 31, 1967—Balance—to Exhibit A-6		66,825.72

STATEMENT OF CAPITAL
For Year Ended December 31, 1967

EXHIBIT M

MEDICAL ANNALS FUND

January 1, 1967—Balance	1,230.39
Addition	
Interest on Savings Account	49.60
December 31, 1967—Balance—to Exhibit A	1,279.99

STATEMENT OF CAPITAL
For Year Ended December 31, 1967

EXHIBIT N

LEWIS H. STEINER FUND

INCOME ACCOUNT

January 1, 1967—Balance	None
Additions	
Bequest from Estate of Walter Ralph Steiner, MD	5,725.13
Investment income	8,087.06
	13,812.19
Deduction	
Reimbursement of General Fund for Purchase of Library Books	4,350.81
December 31, 1967—Balance—to Exhibit A-7	9,461.38

PRINCIPAL ACCOUNT

January 1, 1967—Balance	None
Additions	
Bequest from Estate of Walter Ralph Steiner, MD	383,052.29
Gain on Sale of Securities	533.66
December 31, 1967—Balance to—Exhibit A-7	383,585.95

STATEMENT OF CAPITAL
For Year Ended December 31, 1967

EXHIBIT O

PLANT FUND

January 1, 1967—Balance	723,661.33
Addition	
Assessments	23,265.00
December 31, 1967—Balance—to Exhibit A	746,926.33

STATEMENT OF DEFICIT
For Year Ended December 31, 1967

EXHIBIT P

MED-CHI INSURANCE TRUST FUND

January 1, 1967—Balance			10,826.50
Deductions			
Receipts			
Membership premiums collected			
Accident, sickness and total disability, etc.	412,541.56		
Blue Cross and Blue Shield	222,783.22		
Business overhead and disability	23,674.55	658,999.33	
Retirement program		1,180.00	
Administrative fees		15,032.74	
Interest on United States treasury notes		2,551.08	
		677,763.15	
Disbursements			
Premiums to various insurance companies	658,999.33		
Payroll	10,772.00		
Fees—legal	1,129.00		
consulting	1,859.81		
Postage, stationery and supplies, etc.	2,332.94	675,093.08	
Excess of receipts over disbursements			2,670.07
December 31, 1967—Balance—to Exhibit A			8,156.43

LEGISLATIVE COMMITTEE

Mr. President and Members of the House of Delegates:

Funding of the Medicaid program for the fiscal 1969 year of the State took the limelight during the Legislative Session just completed. At the time of this writing, it is not known what the final results will be although the Faculty will be represented at any of the sessions devoted to this problem.

Legislative bills, complete details of which can be found in the 1968 issues of The Assemblyman, ranged from proposals for changes in the abortion law; the Faculty-sponsored bill for a Commission on Medical Discipline, and to legislation that would permit a physician to use the drug, chloramphenicol, only in hospitals except in emergencies, and also hamstring with red tape any physician who might elect to use this drug on his patients.

A complete listing of all bills introduced into the General Assembly is as follows:

SENATE BILLS

Senate Bill 13.—Providing for new regulations for "Emergency Admission" of persons to mental health facilities under certain circumstances.

Senate Bill 14.—Providing for transfer of patients from State correctional institutions and facilities to mental hygiene facilities.

Senate Bill 15.—Providing for the Department of Public Welfare to notify the Department of Motor Vericles of those persons receiving public assistance for blindness (Hearing, February 5).

Senate Bill 50.—Making it unlawful to sell, transfer or barter glue or glue products to certain minors. THE FACULTY SUPPORTS THIS. (Hearing February 7).

Senate Bill 75.—Implied Consent legislation. THE FACULTY SUPPORTS THIS (Hearing, February 7).

Senate Bill 78.—Increasing the number of medical scholarships from 10 to 20; and amending certain provisions for eligibility. THE FACULTY SUPPORTS THIS.

Senate Bill 101.—Requiring a physician to indicate on the prescription he writes that consumption of alcohol when taken with the medication indicated "may adversely affect or be dangerous to the health of a person."

Senate Bill 102.—Identical to SB 101, except that the pharmacist is substituted for the physician.

NOTE: Senate Bill 101 and 102 were introduced in error in the Senate; they are identical to House Bills 314 and 315 which are the ones on which action will be taken.

Senate Bill 128.—Providing that no hospital or related institution can release any medical records or information concerning any patient receiving treatment without the patient's consent; and requiring the hospital to provide information to the patient upon his request.

Senate Bill 131.—Providing the State Department of Mental Hygiene with authority to use licensed private facilities for mentally retarded or deficient persons when there is a lack of state facilities for such treatment.

Senate Bill 138.—Amending the Medical Practice Act to provide for certain changes in the procedures for donations of bodies or organs for transplant or research. THE FACULTY SUPPORTS THIS, IF AMENDED TO BE CLEARER IN ITS INTENT. (Hearing February 14).

Senate Bill 142.—Providing for state reimbursement of up to 50% of costs of operation of a child care center if used for training purposes and operated by a licensed hospital.

Senate Bill 145.—Creating a program of State Scholarships for training of professional personnel in psychiatric nursing.

Senate Bill 184.—Requiring as part of erection or remodeling of certain public buildings provision for special facilities for handicapped persons.

Senate Bill 231.—Drug Abuse Control law. This would amend Maryland Statutes to conform to the Federal law and permit Maryland investigators to have the same authority as Federal investigators now have. THE FACULTY SUPPORTS THIS.

Senate Bill 235.—Deleting the urine test from the laws as a test for intoxication while driving a motor vehicle.

Senate Bill 236.—Implied Consent legislation similar to other bills reported previously.

Senate Bill 263—Changing from $2.00 to $5.00 the charge for registering a license to practice medicine and surgery in the city or county clerk's office.

Senate Bill 278.—Requiring applicants for public welfare to produce a physician's certificate, if he alleges he is unfit to work because of illness.

Senate Bill 361.—Abolishing the Maryland Hospital Commission and turning its duties over to the State Department of Health.

Senate Bill 370.—Establishing a Board of Dispensing Opticians and establishing a certificate of registration for those practicing opticianry.

Senate Bill 372.—Establishing a Birth Defects Institute under the State Department of Health, which would conduct scientific investigations and surveys of the causes, mortality, methods of treatment, prevention and cure of birth defects.

Senate Bill 382.—Requiring semiannual inspections of school buses.

Senate Bill 383.—Adding "employees of volunteer fire departments" to the Good Samaritan laws.

Senate Bill 387.—Changing laws so that local jurisdictions would have to pay 10% of the cost of caring for mental patients rather than $125.00 annually.

Senate Bill 388.—Maryland Community Mental Health Services Act.

Senate Bill 389.—Alcoholism De-toxification Centers Act, along with deletion of drunkenness as a criminal offense.

Senate Bill 422.—Requiring local jurisdictions to place on deposit certain funds for their 20% share of the medical care program hospital costs.

Senate Bill 426.—Requiring initial and annual examinations of food handlers.

Senate Bill 486.—Placing Optometrists under nonprofit health insurance programs, so that they would be paid, if such services were paid.

Senate Bill 525.—Establishing a Public Hospital Commission to regulate and control hospital costs and charges.

Senate Bill 355.—Providing for medical certificates for minors to obtain work permits only, "if the best interest of the minor is served thereby."

Senate Bill 535.—Providing for pre-mortem and post-mortem authorizations for donations of tissue and organs; and gift of bodies.

Senate Bill 539.—Requiring medical examination of driver if he has had two or more convictions of driving while under the influence of intoxicating liquor or drugs during a five year period.

Senate Bill 540.—Reportable Disease law, authorizing the Medical Advisory Board of the Department of Motor Vehicles to establish a list of diseases or conditions; and requiring physicians to report persons with such diseases or conditions to the MAB, DMV.

Senate Bill 541.—Requiring all new applicants for drivers licenses to provide a medical certificate; to require all persons whose licenses have been suspended or revoked to provide a medical certificate; to require annual certificates from school bus drivers; and to require biennial certificates from those over age 65.

Senate Bill 544.—Providing for educational facilities for emotionally and mentally disturbed children.

Senate Bill 549.—Providing matching funds for community mental health and mental retardation facilities.

Senate Bill 565.—To change law to permit State Health Commissioner to assist in determining rates for payments for Chronic Hospitals.

Senate Bill 580.—Amending Dental Practice Act to prohibit participation by dentists in closed panel practice.

Senate Bill 655.—Providing for a Hospital Cost Control program. The duties of such an Advisory Council would be, among others, "Providing for the establishment of uniform, State-wide reports and audits of payments to hospitals, *to practitioners of medicine* under programs of comprehensive medical and other care in the State of Maryland for indigent and medically indigent persons and to non-profit health insurance plans."

SENATE JOINT RESOLUTIONS

Senate Joint Resolution 3.—To provide for initiation of talks with the District of Columbia Department of Health with respect to milk standards.

Senate Joint Resolution 4.—To provide for a Commission to study guardianship problems posed by the mentally retarded and handicapped persons.

Senate Joint Resolution 33.—Requesting a complete investigation of operation of Medical Care program in Maryland.

Senate Joint Resolution 34.—Requesting those in authority to make full use of general hospital facilities for treatment of Tuberculosis patients.

Senate Joint Resolution 49.—Requesting authorities in public and private elementary and secondary school systems to notify parents when a communicable disease has broken out among his or her pupils.

Senate Joint Resolution 56.—Requesting US Congress to repeal SS amendments dealing with payments for dependent children.

Senate Joint Resolution 57.—Requesting Legislative Council to study the creation of an office of coordinator for Health, Education and Welfare Services under each county and Baltimore City.

Senate Joint Resolution 61.—Requesting the Division of Consumer Protection and Division of Drug Control to undertake an investigation of pricing of drugs and medicine in Maryland.

SENATE RESOLUTIONS

Senate Resolution 18.—Expressing appreciation and good wishes to Isadore Tuerk, MD, Commissioner of Mental Hygiene on the occasion of his retirement.

Senate Resolution 74.—Requesting the Governor to appoint a commission to study the problems relating to Alcoholism, the facilities available to alcoholics and a revision of our present laws.

Senate Resolution 79.—Resolution commending the Shipley family, of which E. Roderick Shipley, MD, is currently President, on its 300th anniversary.

HOUSE BILLS

House Bill 21.—Establishing a Commission on Medical Discipline. FACULTY SPONSORED AND SUPPORTED.

House Bill 47.—A Montgomery County bill that would permit commitment of alcoholics or addicts to local county-operated institutions.

House Bill 88.—Providing for the removal of abortion references from the Criminal Code, and making this a medical determination. FACULTY SUPPORTS THIS.

House Bill 90.—Correction of errors in the Nursing Home Loan Law.

House Bill 169.—Implied Consent legislation, which the Faculty supports in principle. This specific bill needs certain amendments to it before it can be supported in toto.

House Bill 180.—Making it unlawful for a person to be under the influence of . . . amphetamines or barbiturate for which a prescription is required to drive a . . . vehicle."

House Bill 182.—Making it mandatory that any school bus driver have a physical by a physician of his choice and possess a valid chauffeur's license; with physical examinations required biennially thereafter, and to take certain tests.

House Bill 226.—Requiring laboratories to report "findings suggestive of syphilis, gonorrhea and tuberculosis" to the State Health Department; and that the State Health Department may not make contact with the patient without the consent of the attending physician. It further states specifically that, "The result of the laboratory examination does not constitute a final diagnosis of syphilis or gonorrhea."

House Bill 239.—Requiring the Department of Motor Vehicles to

(1) establish minimum physical and mental standards for operators and chauffeurs, and applicants for such licenses.

(2) requiring physician certification that he meets these standards from all new applicants, all persons having their licenses reinstated, all school bus drivers and every operator or chauffeur over 65 years of age.

House Bill 240.—Requiring the Department of Motor Vehicles to require a medical examination from all applicants who have had two convictions for driving under the influence of drugs or liquor in a five year period.

House Bill 241.—Requiring the Department of Motor Vehicles to define physical and mental disorders or diseases which may prevent a person from driving a motor vehicle; and requiring all physicians to report such persons.

House Bills 273, 274, 275, 276.—This package of bills requires the establishment of a Comprehensive Planning Agency in the State; requires that after July 1, 1970, no hospital or related institution can be issued a license unless in compliance with a state plan; requires the State Health Department to develop and revise programs of cost procedures and cost standards and a plan setting forth the services and facilities required of hospitals in order for such units to receive state funds; and sets up a hospital review commission to approve the previous procedures and standards.

House Bills 283, 284.—This package, with various amendments, is supported by the Faculty. It amends the authority of the Chronic Disease Hospitals so as to permit them to have post-discharge and pre-admission evaluation clinics; permits them to engage in research and related activities; and changes the manner in which local boards are appointed.

House Bill 300.—Requiring hospitals to furnish an itemized bill clearly describing the item and amount charged thereof. It was co-sponsored by 33 members of the House.

House Bill 314.—See Senate Bill 101.

House Bill 315.—See Senate Bill 102.

House Bill 338.—Establishing certain requirements for riders of motorcycles in the State.

House Bill 352.—Redefine criminal charge of drunk and disorderly conduct, establish procedures for law enforcement officers; and provide care of habitual offenders.

House Bill 380.—Making it unlawful to use Jimson Weed.

House Bill 425.—Requiring the Department of Education to include in courses of instruction, the use and abuse of dangerous and narcotic drugs.

House Bill 440.—Drug Abuse Control Law—See Senate Bill 231

House Bill 488.—Establishing a program of state scholarships for nursing education.

House Bill 518.—Amending the laws extending the definition of "Radiation."

House Bill 523.—Amending the law to prohibit payments to vendors of medical services under the medical assistance program unless the invoice is received before the maximum elapsed time established by the U.S. Department of HEW.

House Bill 526.—Requiring public buildings to be constructed with facilities for the handicapped.

House Bill 574.—Requiring the State Department of Health to hold annual hearings to determine which drugs can be prescribed by their generic names; and to restrict the pharmacist fee to 20% of the wholesale cost. This is all applicable to Maryland's medical assistance program.

House Bill 623.—Establishing licensure for hearing aid dealers.

House Bill 654.—Establishing that the State Department of Health shall have subrogation rights for medical assistance program patients.

House Bill 674.—Permitting the courts to sentence drug addicts to medical institutions.

House Bill 687.—Creating an Office of Disaster and Emergency Planning.

House Bill 700.—Abolishing the Maryland Hospital Commission. See Senate Bill 361.

House Bill 705.—Amending the Health Code to permit persons other than those licensed or certified by the State to participate in the medical assistance program.

House Bill 740.—See Senate Bill 389.

House Bill 741.—See Senate Bill 388.

House Bill 742.—See Senate Bill 422.

House Bill 757.—Implied Consent legislation.

House Bill 758.—Providing penalties for harmful inhalants, their sale, etc.

House Bill 803.—Providing for registration of those practicing massage.

House Bill 845.—See Senate Bill 383.

House Bill 944.—Providing for allocation of series MD license plates to be allocated for use of members of Medical and Chirurgical Faculty.

House Bill 974.—Providing for full payment of health insurance for state employees.

House Bill 987.—Increasing visual acuity requirements for drivers' licenses; and changing period of time from one year to 90 days that a person who loses the sight of one eye must refrain from driving.

House Bill 1014.—Changing the requirement for registration of legislative agents.

House Bill 1017.—Establishing a Department of Air and Water Quality Control.

House Bill 1022.—Permitting pharmacists to substitute generic drugs on physician's prescriptions at the request of the patient.

House Bill 1071.—Prohibiting members of hospital boards or relatives of such members from serving on boards of non-profit health insurance corporations.

House Bill 1083.—Providing for a Board of Hearing Aid Examiners and licensing hearing aid dealers for the sale of hearing aids.

House Bill 1087.—Including Podiatrists under various categories of insurance policies so that they can be paid if benefits are provided for services they are licensed to perform.

House Bill 1091.—Changing the Board of Physical Therapy Examiners from a total of seven (five physicians and two PTs); to a total of five (two physicians and three PTs).

House Bill 1092.—Changing licensure requirements for Physical Therapists, including the requirement that examinations be held at least semiannually.

House Bill 1112.—Requiring that the drug, chloramphenicol, shall be used only in a hospital; that a physician may use it outside a hospital only in an emergency and provided he completes certain written information in a form prescribed; and authorizes the State Health Department to establish certain regulations in this respect.

House Bill 1114.—Regulating burial contracts before death.

House Bill 1130.—Establishing new regulations for those persons who are serving as legislative agents.

House Bill 1185.—Amending Health Code to permit Chiropractors to participate under the Medical Assistance Program.

House Bill 1191.—Requiring Ambulance Drivers and others to have completed Red Cross First Aid Course in order to qualify under Good Samaritan Law.

House Bill 1212.—Requiring the Board of Pharmacy to require all drugs manufactured for intrastate use to comply with FDA standards for manufacture.

House Bill 1216.—Providing for Disciplinary procedures for Board of Optometry Examiners (this bill is almost identical to Faculty bill dealing with Commission on Medical Discipline).

House Bill 1224.—Exempting physicians from requirements of laboratory registration laws of State.

House Bill 1280.—Providing for an insurance system of the State to insure mortgage payment loans for non-profit hospital corporations.

House Bill 1317.—Changing the Motor Vehicle Laws to provide that each applicant for license renewal must include a certificate of physical fitness to drive.

House Bill 1318.—Implied Consent proposal.

House Bill 1347.—Providing for licensing of ambulances or other vehicles used for the transportation of ill or injured; and establishing an Advisory Council on such licensure.

House Bill 1348.—Exempting physicians from the laboratory licensing laws.

HOUSE JOINT RESOLUTIONS

House Joint Resolution 1.—Requesting the State Board of Health and Mental Hygiene to undertake a study of transportation of the mentally ill.

House Joint Resolution 7.—Expressing the intent of the General Assembly when it adopted Senate Bill 315, the Parental Consent legislation in the 1967 General Assembly.

House Joint Resolution 56.—Directing the State Health Department to make a study and reports on the use of the drug, chloramphenical, during the years 1966, 1967 and 1968; and indicating the information to be contained in such a report.

House Joint Resolution 60.—Requesting Legislative Council to study programs relating to physical fitness in Maryland.

House Joint Resolution 76.—Requesting the Governor to name a Committee to investigate feasibility of neighborhood centers to combat drug and narcotic problems; and to study use of methadone treatment on a state level.

House Joint Resolution 77.—Suggesting to the Governor under the new proposed State Constitution a proposed reorganization of the Departments of Health and Mental Hygiene.

House Joint Resolution 80.—Urging State to appoint a Commission to study Baltimore City Hospital and its program and financing and development.

Respectfully submitted,

B. Martin Middleton, MD, *Chairman*
I. Rivers Hanson, MD
Karl F. Mech, MD
Howard Moses, MD
Stephen K. Padussis, MD
Belden R. Reap, MD
J. Morris Reese, MD
Wm. Schunick, DDS
Mrs. DeWitt E. DeLawter

LIAISON COMMITTEE

Mr. President and Members of the House of Delegates:

This Committee with its varied sub-committees held a number of meetings during the year dealing with many aspects of practice and cooperation with other medical disciplines.

Among the codes and reports worked out by the sub-committees were the Physician/Pharmacist Code of Co-operation; a joint statement of the Role of the Registered Nurse in the Care of the Patient with Cardiovascular Diseases in Coronary Care of Intensive Care Units, and a Report on Radiology Services by the Sub-committee on Radiology Services.

A new Nursing Home liaison subcommittee was named. The subcommittee on Medicine and Religion, rather than initiating any major programs on a state-wide basis, is offering assistance and advice in local situations where requested.

When the Faculty Council rejected the Committee's endorsement that laboratories be required by law to report findings suggestive of tuberculosis and syphilis, this committee then voted that the Council be asked to reconsider this matter, and recommended that a Committee representative together with State Health Department representatives be present to answer questions and clarify any controversial points in the proposed law.

The dangers of indiscriminate weight reduction programs conducted by physicians whose "procedures were somewhat questionable" came before the committee. Through a press release the public was being alerted to the dangers of such programs, and an extensive investigation into this type of practice had been conducted by the Faculty it was learned.

The Committee's recommendation to Council had been approved pertaining to imprinting of prescription blanks as follows: Approval of the policy that prescription blanks printed for physicians after January 1, 1968, shall not contain printed information indicating refills.

Many other questions of professional procedure with ancillary professions came under discussion and while no motions or resolutions resulted, better understanding and cooperation with the medical profession was made possible.

Respectfully submitted,
William L. Stewart, MD, *Chairman*
Melvin N. Borden, MD
Robert E. Farber, MD
Paul F. Guerin, MD
John H. Hirschfeld, MD
John Kehoe, MD
John F. Schaefer, MD
Joseph P. Cappuccio, DDS
W. Kenneth Mansfield, MD
H. Leonard Warres, MD
Donald W. Mintzer, MD
William J. Peeples, MD

LIBRARY AND HISTORY COMMITTEE
FINNEY FUND COMMITTEE

Mr. President and Members of the House of Delegates:

During 1967 the Library and History Committee experienced a change in chairmanship and activated the survey evaluation approved earlier which is being conducted by Mr. Lee Ash.

Considerable increase in acquisition of new books has been possible also, due to the new Lewis Henry Steiner Fund for the purchase of books and journals. A number of gaps have been filled which otherwise would not have been possible.

The staff situation continues to fluctuate as librarians are still not plentiful. However, after Mrs. Raquel Cabanilla left for a position at Pratt Library, Mrs. Arlene Grede, a part-time professional assistant, assumed part of the cataloging duties. Miss Beatrice Marriott, formerly with the Health Sciences Library, University of Maryland, began working as part-time reference assistant in March and Miss Sarah Katzoff returned during the summer. Afterward the library was fortunate in securing Mrs. Jane Parsons as part-time assistant librarian in charge of cataloging and ordering.

At end of the year the staff situation was: one full-time professional librarian, one half-time professional assistant librarian, one part-time professional reference librarian, two part-time clerical assistants, three part-time student assistants, and maid part-time. This still reflects a staff composed of one full time professional librarian, two part time professional assistants, and the remainder of the staff part time.

During the year Mrs. Sanford, librarian, attended three national library organization meetings: Representative on Advisory Council, Special Libraries Association, Houston, Texas; Special Libraries Association, New York City; Medical Library Association, Bal Harbour, Florida, and the regional meeting of the Medical Library Association, Washington, D. C. She also participated in several local medical library meetings, was president of the Baltimore Chapter, Special Libraries Association for 1966/1967, and treasurer of the Baltimore Hospital Libraries Association.

New shelves were added to the abstracts alcove in order to provide space for the expanding series of Excerpta Medica and other specialty abstracts. A double faced two-section unit of periodical shelving was also installed in the periodical room. A two-drawer letter size file was added for cataloging, as well as two posture chairs.

As usual, the library provided a collection of books for the annual and semiannual meetings. There was also an exhibit of Lister Centennial materials arranged by Miss Marriott at the annual meeting at the Alcazar. An additional exhibit, including bibliography on sports medicine, was prepared for the Seminar on Sports Medicine held at Catonsville Community College.

Regarding the "Ash Survey," much progress has been made in segregating various types of volumes, that is, rare, history of medicine, salable, and discard. A clerical assistant follows Mr. Ash in recording the rare and history of medicine volumes, then moves the others as indicated by colored tabs inserted in the books by Mr. Ash. There are now quite a few discards to be disposed of, a problem in itself, since all these volumes have to be withdrawn from library records and then physically destroyed or carted away. Many valuable items have been discovered through this survey and, when completed, professional assistants will be needed to process the rearrangement and recataloging of the collection.

In November 1967 Dr. Krause, after many years of service as Chairman of the Library and History Committee, resigned as Chairman, but agreed to remain on the committee. It was with much genuine regret that the committee accepted Dr. Krause's resignation. Dr. Paul Guerin was elected to succeed Dr. Krause and immediately proposed that the Library and History Committee recommend that suitable recognition be expressed for Dr. Krause's years of service on the committee and for the improvement of the Medical and Chirurgical Faculty Library.

Respectfully submitted,

Library and History Committee

PAUL F. GUERIN, MD, *Chairman*
LOUIS KRAUSE, MD
H. BALDWIN STREETT, DDS
ROBERT B. GOLDSTEIN, MD
THOMAS C. HILL, MD
KATHARINE A. CHAPMAN, MD

Finney Fund Committee

D. C. W. FINNEY, MD, *Chairman*
RICHARD W. TELINDE, MD
RICHARD V. HAUVER, MD
JOHN P. HABERLIN, MD
RICHARD G. COBLENTZ, MD

LIBRARY STATISTICS—1967

Circulation	
Journals	3,686
Books	1,953
Pamphlets (VF)	250
Reprints	100
Total	5,989
Attendance	2,475
Courtesy cards issued	8
Bibliographies	181
Pages xeroxed	6,966
Acquisitions	
Books	630
Journals	708
Total	1,338
Gifts	
Books	150
Journals	328
Total	478
Telephone reference calls processed	3,065
Total volumes in collection	94,474

MARYLAND MEDICAL POLITICAL ACTION COMMITTEE

Mr. President and Members of the House of Delegates:

Since its origin in 1962, MMPAC has now passed through its infancy into adolescence and will achieve maturity, we trust, in the not too distant future. More

and more physicians of Maryland are continuing to see the need for responsible political action. For the moment this is carried out at the Congressional level only. We hope more and more of our fellow physicians will also join us—financially if not vocally and allow expansion of activity.

Our 1966 election activity assisted a freshman Congressman who understands well the purpose and the help of MMPAC. In the meantime, two incumbents successfully remained in office with our support—a factor of great importance.

We approach the elections of 1968 determined to add a new, clear-thinking mind to the Congress while maintaining our previous gains. We ask this governing body to continue to support us in thought, word and deed and help us achieve our purpose.

Again we thank you for your vital assistance in the past and hope it will continue to grow in the future.

Respectfully submitted,

Joseph H. Hooper, Jr., MD, *Chairman*

MARYLAND MEDICAL SERVICE, INC. BOARD OF TRUSTEES

Mr. President and Members of the House of Delegates:

Without doubt, 1967 was the busiest year in the history of the Plan. This statement applies equally to our underwritten business and that which was fiscally administered for the Federal Government.

During the year enrollment increased by 44,582 (4.7%), bringing our total membership to 990,588 at the end of the year. Although national year-end figures were not available for comparison at the time this report was written, those for the first nine months had been developed. As of September 30th, Maryland Blue Shield's enrollment gain of 2.85% was well above the national average of 2.37%. Our Plan is the 17th largest among the 83 Plans in the United States, Canada, and Puerto Rico. In our regular underwritten business we cover 36.72% of the population in the area we serve, as compared with a national average of 29.01%. At the end of the year our membership was 82.5% of that of our companion Blue Cross Plan; at the same time in 1966 the comparable figure was 80.5%.

Claims in the amount of $18.2 million were incurred in our underwritten programs during 1967, an increase of $1.5 million (9%) over the previous year. This comprised 446,478 processed claims, an average of about 8,600 per week. Of this total, 43% were of a surgical nature (with about two-thirds having been provided in physicians offices or hospital outpatient departments), 9% were medical, 4% obstetrical, 11% anesthesiological, 14% pathological, 15% radiological, and the remaining 4% comprised consultations and miscellaneous diagnostic services. Professional anesthesiology was provided in 59% of the inpatient surgical and obstetrical cases, and 36% of the consultations covered were of the multisystem nature.

There was a net gain of 325 participating physicians in 1967, the year-end total reaching 3,775 or 91.5% of those doctors who submitted claims. The following table shows the degree of physician participation by county:

Geographic Analysis of Physicians Participation
December 31, 1967

County	Participating Physicians	Non-Participating Physicians	Percentage Participating Physicians
Allegany	85	7	92.4
Anne Arundel	164	6	96.5
Baltimore City	1,786	166	91.5
Baltimore County	281	37	88.4
Calvert	6	0	100.0
Caroline	9	0	100.0
Carroll	37	1	97.4
Cecil	21	1	95.5
Charles	15	0	100.0
Dorchester	18	4	81.8
Frederick	56	1	98.2
Garrett	8	0	100.0
Harford	66	4	94.3
Howard	16	1	94.1
Kent	13	1	92.9
Montgomery	513	65	88.8
Prince George	224	12	94.9
Queen Anne's	5	0	100.0
St. Mary's	17	0	100.0
Somerset	10	2	83.3
Talbot	29	3	90.6
Washington	94	9	91.3
Wicomico	54	20	73.0
Worcester	11	0	100.0
Out of State	237	19	92.6
Total	3,775	359	91.5%

N. B. The figures for "Out of State" comprise physicians in Pennsylvania, Virginia, and West Virginia who regularly submit claims for services to Maryland subscribers.

The members of our Professional Relations Department visited 2,547 physicians' offices during the year, and their office assistants. Of these meetings, seven were those of county medical societies, the Blue Shield representatives attending with the Faculty's Executive Secretary. Needless to say, at most of the meetings and office visits, Medicare questions were heavily in the majority.

In March, Plan C, the new usual and customary fees program, was approved by the State Department of Insurance for offering to group accounts. The first large group to purchase this new coverage, designed to pay a physician's usual charge for a covered service, as long as it is within the range of charges customarily made for a similar service by most physicians in the same community, was the Bethlehem Steel Corporation. Employees of Mack Trucks, Inc. and Schenuit Industries, Inc., are also covered under this new program. By the end of the year about 120,000 persons were enrolled under Plan C.

Again in 1967, the administration of Part B (Supplemental Medical Insurance) of Medicare required a great deal of attention and hard work by the Plan's staff. We started the year with a substantial backlog of claims, as did all other carriers. Large amounts of overtime work, together with substantial systems redesigning and computer reprogramming, eliminated the backlog by midsummer, however, and since then the program has been on a current basis. Medicare B claims are being received at the rate of over 1,000 a day and, in all likelihood, the volume will increase steadily. During the year Maryland Blue Shield paid out $8,964,674 in benefits under the Medicare B program.

Another $486,132 was paid to Maryland physicians under CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) last year. This program provides a broad range of benefits for dependents of active duty servicemen, and retired military personnel and their dependents.

The Board of Trustees joins me in expressing appreciation to the entire staff at Blue Shield for the great amount of time and effort they have expended in so successfully conducting the business of the Plan during the year.

Respectfully submitted,

J. Sheldon Eastland, MD, *President*
Maryland Medical Service, Inc.

MARYLAND STATE MEDICAL JOURNAL

Mr. President and Members of the House of Delegates:

C. Thomas Flotte, MD, assumed the position of editor of the Journal and chairman of the Editorial Board during 1967, a year that also marked several changes in personnel. At the end of the fiscal year, Miss Judy Sowell was to take up her duties as managing editor of the Journal.

A manuscript problem existed throughout the year and the cooperation of the editorial board as well as all members of the medical society and various specialty group meetings was being sought in providing new sources of scientific material.

The editorial board recommended that the Journal participate in a project to microfilm the past five years issues of the Journal. This would be done by Academic Archives, Inc. and the Xerox Corporation which would then sell to new medical libraries the microfilm copies. This would obviate the necessity to purchase back issues of Journals, many of which are not readily available. On completion of the microfilming, the back issues would receive some royalty on any sales of these microfilms. All AMA journals and specialty journals have become involved in this propect, and after discussion, the Editorial Board recommended to the Executive Committee that this project be approved and implemented forthwith, subject to approval of legal counsel.

The acceptance of liquor and tobacco advertising was discussed and while present policy is not to accept such advertising, the question of acceptance of liquor advertising was to be studied in light of AMA policy.

Set policy on the acceptance and control of form of various "pages" in the Journal written by different groups was formulated. The amount of space allocated to such pages, frequency of their appearance and whether or not these should be utilized depending on the type of article present for publication came under discussion.

Respectfully submitted,

C. Thomas Flotte, MD, *Editor*

Editorial Board:

Leon W. Berube, MD
Houston S. Everett, MD
E. T. Lisansky, MD
Richard L. Masland, MD
Moses Paulson, MD
Edward C. H. Schmidt, MD

MED-CHI INSURANCE TRUST

Mr. President and Members of the House of Delegates:

The Med-Chi Insurance Trustees held frequent sessions during the year in their efforts to continually improve the existing programs and to study the feasibility of new programs.

The Med-Chi Members Retirement Plan was initiated at the end of 1967. Many hours were spent in hearings and comparing various Keogh type programs. After long study and careful consideration, a program was finally designed expressly for the Faculty in which the Mercantile Safe-Deposit and Trust Company serves as Trustee, the T. Rowe Price Company serves as Investment Consultant, and the Shenandoah Life Insurance Company offers guaranteed issue life insurance. The retirement plan was approved by the Council at a special meeting on October 5, 1967.

Changes are being made in the health and accident insurance program. As a result of good experience, the Program of Weekly Indemnity and Major Medical coverage will offer more liberalized benefits beginning May 1, 1968. The premium rates will remain the same. As soon as the changes are cleared through the State Insurance Commissioner's office, new brochures will be sent to the Faculty members.

The Trust now administers the following programs: (1) Health & Accident Insurance; (2) Major Medical & Accidental Death Insurance; (3) Blue Cross & Blue Shield; (4) Business Expense Disability Insurance; (5) Life Insurance and (6) Retirement Program. Periodic reports on the progress and experience of each program are required by the Med-Chi Trust. This close attention to the programs will enable the Trustees to constantly maintain programs that are financially sound and economical for the members of the Faculty.

Respectfully submitted,

Paul F. Guerin, MD, *Chairman*
Harry J. Connolly, MD
Philip A. Insley, MD
William J. McClafferty, MD
Alfred S. Norton, MD
Richard A. Young, MD

MEDIATION COMMITTEE

Mr. President and Members of the House of Delegates:

Once again, the Mediation Committee was required to meet almost on a monthly basis during the year just concluded. A complete numerical listing of all cases coming before the Committee, as well as before Component Society Mediation Committees is appended at the conclusion of this report.

As in previous years, our Committee was called upon to handle the more serious complaints involving physicians. In addition, innumerable queries regarding specific ethical problems were discussed and conclusions provided to the inquirer.

Last summer a Subcommittee of our group concluded a study of the practices of physicians who devoted a substantial portion of their practice to weight reduction. Following the study a press release was issued and carried by most of the newspapers in the State. This dealt with a caution to the public about weight reduction and that there was no easy panacea to this problem except calorie-counting and proper exercise, all under the supervision of their family physician.

Our worst fears were realized early in 1968 when the U.S. Senate started hearings on this subject; and the Baltimore Sunday Sun carried an exposé of one physician's particular practices in this regard. We were happy to have foreseen this and to have garnered at least some favorable reaction in having been alerted to this problem before it was brought to the public's attention.

Various recommendations have been made to the Council during the year. A complete listing of these can be

found in the report of the Council to the House of Delegates.

Because of the importance of communicating with physicians, bringing to their attention the ethical matters with which they should be familiar, it was decided to ask the Board to include a one-day examination or lecture in these subjects at the times of Board examinations. This matter is still pending. The February, 1968, issue of the *Maryland State Medical Journal* was devoted to Ethics. Various changes in the applications for licensure and examination were suggested to the Board and these will be incorporated into these applications.

The Committee was also asked to evaluate the "Man Alive Research Program" a program to assist drug addicts by prescribing Methadone for their use. A subcommittee was formed for this purpose to which representatives of federal, state and local governmental jurisdictions were invited. It was a worthwhile session and the Subcommittee found the objectives of the program were highly commendable and that with adequate controls and certain improvements and refinements, the Faculty should support this idea and concept. The Committee also recommended to the Council that policies with respect to physician listings in yellow pages be adopted on a statewide basis. This policy has now been adopted and is in existence.

It is felt that this will enable physicians to adequately identify themselves for the public convenience, and also retain certain dignity in such listings.

The Committee still has several rather serious complaints before it. It is hoped when certain clarifications are obtained these can be disposed of in a proper manner.

The Committee is also convinced more than ever of the need for the Commission on Medical Discipline. It is hoped that this will be enacted into law this year. It is expected that this will have a salutory effect on the chronic offenders against medical ethics, reflecting a poor image to the public.

(Continued next page)

	Mediation Cases 1967 Total	Cases for Complainant	Cases for Defendant	Cases Pending at 12/31/67	Cases Settled Mutually	No Action	Referred to Board of Medical Examiners	Reprimanded
Allegany County	0							
Anne Arundel County	0							
Baltimore City	59	0	37	10	12			
Baltimore County	7		7					
Calvert County								
Caroline County	0							
Carroll County	0							
Cecil County	0							
Charles County								
Dorchester County	0							
Frederick County	0							
Garrett County	0							
Harford County	4		4					
Howard County	0							
Kent County	0							
Montgomery County	39	1	21	5	12			
Prince George's County	20	8	11	1				
Queen Anne's County	0							
St. Mary's County	0							
Somerset County	0							
Talbot County	0							
Washington County	4	1	2	1				
Wicomico County	1		1					
Worcester County	0							
CASES HANDLED ON STATE LEVEL	52	8	11	7	10	3	13	*7

* Included in cases for complainant.

The Committee has empowered our legal counsel to meet with the Attorney-General's office to discuss the current backlog of matters that exist in the Board of Medical Examiners office and on which, in some case, prosecution should be undertaken. We are of the firm opinion that this is one of the most important committees of the Faculty. The intense devotion to upgrading the standards of physicians exemplified by the members of this group cannot be praised too highly by the Chairman.

Respectfully submitted,

Wolcott L. Etienne, MD, *Chairman*
John Murray Dennis, MD
Howard F. Kinnamon, MD
Charles F. O'Donnell, MD
M. McKendree Boyer, MD
Robert vL. Campbell, MD
John T. Chissell, MD
J. Morris Reese, MD
Russell S. Fisher, MD
Robert B. Goldstein, MD
Lewis P. Gundry, MD
E. L. Pessagno, DDS
Louis J. Kolodner, MD
John F. Schaefer, MD

MEDICAL ANNALS OF MARYLAND COMMITTEE

The Medical Annals of Maryland Committee has no report to submit to the House of Delegates.

Leslie E. Daugherty, MD

MEDICAL ECONOMICS COMMITTEE

Mr. President and Members of the House of Delegates:

During the year the name of this committee was changed to that shown. This reflects more accurately the activities of our group and clarifies some of the misunderstandings that have occurred in the past. During the year 4 meetings of the Committee were held. The first was devoted to preparation of an educational program to be made available to component medical societies of the Faculty dealing with prevention of Professional Liability Claims.

The second meeting was devoted to an in-depth analysis of the operation of the St. Paul Companies "group" program during the 1967 year. Unfortunately, one substantial loss requires an average 18% increase in the premium structure at the next renewal date for individuals. This will still be less than the national Bureau rates for Maryland.

Approval was given to permit the St. Paul Companies, in order to protect the program of the Faculty, to consider establishing maximum limits *on an individual basis* when substantial losses occur with one policy-holder. The insured could then obtain additional excess coverage through another insurer.

At the suggestion of legal counsel an attempt is to be made to have the educational program presented at hospital staff meetings throughout the metropolitan areas of Baltimore and Washington. We still believe much can be accomplished by alerting physicians and other medical allied personnel to the common errors that create claims.

The Committee has also continued to review physicians' bills for health insurance companies which provide major medical insurance. These reviews determine, where necessary, if the fee is indeed, Usual, Customary and Reasonable. It speaks well for Maryland that relatively few of these problems are brought to the attention of the Committee.

Respectfully submitted,
W. Kenneth Mansfield, MD, *Chairman*
Arthur Baitch, MD
Gilbert L. Banfield, MD
Edward M. Barczak, MD
Samuel H. Bryant, DDS
Thomas Crawford, MD
Alfred S. Norton, MD
Eldridge H. Wolfe, MD (deceased)

MEDICAL EMERGENCY DISASTER SERVICES COMMITTEE

Mr. President and Members of the House of Delegates:

This committee was named by the Council to undertake a study of medical and surgical emergency problems related to highway accidents and the possible use of helicopters for transportation of injured. In this regard a letter was sent to the State Commissioner of Health indicating the desire of the Faculty to work with the Health Department in this area. This was to eliminate various groups working at cross purposes.

Council, on the other hand, rejected this committee's recommendation that a committee be appointed to investigate utilization of hospital emergency rooms as "Family Doctors" to the public. It was felt by Council that this was a purely local problem which had been studied thoroughly. This committee, however, disagreed and felt that it was a nation-wide problem and the group will continue to gather information and data re-enforcing its opinion so that the subject can be re-introduced to Council.

A Rescue and Emergency Care Program being offered by the University of Maryland was outlined to the committee by Richard Ronk, coordinator. This course evolved from a volunteer firemen's program 30 years ago and then was expanded into rescue training. The purpose of the course is to provide additional ambulance attendant training.

Various other disaster training seminars and programs being held both in Washington, D. C. and in Maryland were outlined for the committee.

Respectfully submitted,

Charles J. Savarese, MD, *Chairman*
Raymond M. Cunningham, MD
E. Roderick Shipley, MD
R. Lane Wroth, MD
Edward L. J. Krieg, MD
Kirk Moore, MD
William J. Peeples, MD
Robert J. Wilder, MD
Kenneth Philbrook, MD
Gina M. Glick, MD

MEDICOLEGAL COMMITTEE

Mr. President and Members of the House of Delegates:

The Committee has had only two meetings during the past year. Subcommittee meetings have been held, however, at which considerable business has been transacted.

The Subcommittee on Interprofessional Relations has had several fruitful meetings at which differences between physicians and attorneys have been ironed out. Fortunately, the physicians involved have been amenable to suggestions from this joint group and we have no outstanding matters pending in this area. Some of the attorneys involved have declined to answer queries ad-

dressed to them and appropriate action, is being contemplated by the legal representatives on this committee.

The Subcommittee on Court Procedures has under consideration the establishment of a Medicolegal screening panel to evaluate malpractice actions against physicians and decide on their merit. This type of procedure is in effect in some other states and has been reported operating in a successful manner. No firm decisions have been reached in this regard.

The Subcommittee on Symposia sponsored the annual session for attorneys in December 1967, at which the subject was Areas of Mutual Concern in Drug Abuse. The meeting was well attended by attorneys and excellent press coverage was received.

Respectfully submitted,

ROBERT W. JOHNSON, 3RD, MD, *Chairman*
CONRAD ACTION, MD
JAMES G. ARNOLD, JR., MD
HOWARD F. KINNAMON, MD
J. ELLIOT LEVI, MD
F. FORD LOKER, MD
BELDEN R. REAP, MD
WILLIAM G. SPEED, 3RD, MD
JOHN F. STRAHAN, MD
JAMES D. DRINKARD, MD
PAUL HUFFINGTON, JR., MD
RUDIGER BREITENECKER, MD

MEMBERSHIP COMMITTEE

Mr. President and Members of the House of Delegates:

The Membership Committee held three meetings during the past year. A recommendation that special recognition be given to those Faculty members or other worthy individuals who have worked on behalf of the profession was made to the Council and was adopted.

In addition, much time and effort was given to the question of admission of Osteopathic graduates who have licenses to practice medicine and surgery in Maryland, as well as the question of hospital staff privileges for such persons. A summary follows.

In 1967, with the concurrence of the Medical and Chirurgical Faculty of the State of Maryland, the Medical Practice Act was amended so that (1) Osteopaths licensed by the Board of Osteopathic Examiners who had graduated from Osteopathic College in or after 1940 and who were resident and practicing in Maryland on June 1, 1967, could receive a license from the Board of Medical Examiners to practice medicine and surgery (allopathic medicine); (2) those graduating before 1940 could receive the same license, provided they completed refresher courses suitable to the Board of Medical Examiners; (3) those Osteopaths not licensed by the Board of Osteopathic Examiners graduating after 1940 could apply for examination by the Board of Medical Examiners if they complete one year's training in an *approved* hospital. At the time of the adoption of this proposal by the Faculty, the only national accrediting body for postgraduate training programs approved by the U. S. Department of Education was the AMA's Council on Medical Education. Since then, the U. S. Department of Education has approved the American Osteopathic Association's equivalent council.

Since June 1, 1967, licenses to practice medicine and surgery have been granted on an automatic basis to ten osteopaths. In addition, one osteopath has applied for licensure examination and has taken the examination in December 1967, but did not pass.

In June 1967, the American Medical Association's House of Delegates adopted the policy that the presently existing five Osteopathic Colleges should be converted into Schools of Medicine. Thus, it is most likely that in ten years there will be no more Osteopathic Colleges.

Osteopaths, once they obtain licensure to practice allopathic medicine, appear to forsake the cultist aspects of osteopathic practice, and devote themselves solely to allopathic medicine. What remnants of their osteopathic principles they retain and use could be compared to the practice of Physiotherapists. (Note 1)

It is felt that within a few years, there will be an influx of osteopaths into the smaller communities throughout Maryland. These physicians will be rendering first-line medical care. They will want to have hospital privileges, and local communities will be demanding that right for them.

In view of this, it is important that the Medical and Chirurgical Faculty of Maryland consider (1) Medical Society membership for osteopaths, and (2) Hospital privileges for osteopaths licensed by the Board of Medical Examiners.

Other State Actions

Other states have been concerned with medical/osteopathic relations for some time. In Michigan, which has the largest number of Osteopaths in the country, Osteopaths have their own hospitals and their own professional organization. In California, with (at one time) the second largest number, the osteopathic law was repealed a few years ago and all osteopaths were given the degree of MD (DO). Osteopaths were then taken into a 41st Medical Society (Note 2) and, as they qualified, transfered to the local county medical society.

In New York State, the following policy has been adopted:

> "It is the sense of the Council that active membership in this Society should be limited to graduates of recognized medical schools who have completed not less than four satisfactory courses of at least eight months each in a medical school in this country or Canada registered as maintaining at the time a standard satisfactory to the Department of Education or in a medical school in a foreign country maintaining a standard not lower than that prescribed for medical schools in this State, and that the County Societies amend their constitutions and bylaws accordingly." (Note 3)

Maryland

Maryland is unique in that it has gone through a similar transition period with the Homeopathic physician. To refresh the memories of those who may have forgotten, and to acquaint newer Faculty members with the history, it is necessary to give the following brief background:

The Homeopathic Board of Medical Examiners was established in 1892. It issued licenses for many years but as the last Homeopathic Medical School became a fully-accredited medical college, there became fewer and fewer homeopathic physicians. Unscrupulous physicians then obtained control of the Homeopathic Board of Medical Examiners and began selling licenses to unqualified persons. It is believed some of these licenses are still in use. Following investigation and criminal indictment of the person responsible, the state legislature, in 1957, abolished the Homeopathic Board and vested all licensure rights in the Board of Medical Examiners.

The Osteopathic Board cannot be similarly abolished since many osteopaths throughout the country still hold Maryland *Osteopathic* licenses and do not meet the requirements for automatic Maryland allopathic licensure. Therefore, the Board must remain in existence. In time it will be abolished as fewer and fewer *purely osteopathic* licenses remain in force.

Maryland is also unique inasmuch as there are only ten osteopaths who have obtained automatic licensure. All future graduates of osteopathic colleges must pass the written medical examination before obtaining the allopathic license.

Current Policy

The Medical and Chirurgical Faculty has ruled that it is ethical for a physician to voluntarily associate with Doctors of Osteopathy, provided the DO has been licensed by the Board of Medical Examiners. The Joint Commission on Accreditation of Hospitals has adopted the following policy with respect to hospital privileges for Osteopaths:

> "The governing body of a hospital is responsible for the care given to patients in the hospital. It delegates the prime responsibility for the provision of all medical care to the jurisdiction of the organized Medical Staff of the hospital. Membership on the Medical Staff may be granted only to qualified Doctors of Medicine and Doctors of Osteopathy who may admit patients to the hospital under the provisions of the By-laws, Rules and Regulations of the Medical Staff which have been approved by the governing body of the hospital."

In a New York court case in 1965, it was ruled that the medical society has the right to continue to limit its membership to those who are graduates of colleges of medicine, *unless it is a party to a monopoly or the osteopath requires membership as a matter of economic necessity*. Therefore, where there is only one hospital in a community and it requires medical society membership for the granting of privileges, denial of membership could result in economic hardship. Once such membership has been granted, the osteopath then apparently has the right to have his qualifications for membership on the hospital staff fairly considered by the hospital. There is a 1966 New Jersey decision to this effect.

The Membership Committee, therefore, recommends:

1. **Appropriate changes be made in Faculty Bylaws so that component medical societies may admit to membership graduates of colleges of osteopathy, who are duly licensed to practice medicine and surgery in Maryland, applying the same standards used in deciding membership of a doctor of medicine.**
2. **The present application blank for Faculty and Component medical society membership be amended with the addition of the following or similar words: "I hereby agree to confine my practice of medicine to scientific principles, as enunciated by my peers."**
3. **That the matter of hospital staff membership is a decision for each individual hospital. The same standards used by a hospital in deciding whether staff privileges should be extended to a doctor of medicine should be used in deciding whether staff privileges should be given to a doctor of osteopathy. Inasmuch as it is important that each hospital, if at all possible, be accredited by the Joint Commission on Accreditation of Hospitals, the policy laid down by the Joint Commission pertaining to hospitals with integrated staffs should be observed.**

In addition to the above activity, the Committee has overseen the updating of the membership booklet outlining the services offered through Faculty and Component membership.

Respectfully submitted,

Samuel Borssuck, MD, *Chairman*
William G. Helfrich, MD
Frank T. Kasik, Jr., MD
H. David Kerr, MD
Wallace H. Sadowsky, MD
Emmanuel A. Schimunek, MD
Raymond M. Yow, MD

Note 1 and 2—Address by Samuel P. Newman, MD, Denver, Colorado, at the meeting of legal counsel to State Boards of Medical Examiners, Palmer House, Chicago, Ill., February 8, 1965.

Note 3—Medical Opinion and Review, December, 1967.

NECROLOGY

Allegany County	
Doerner, Wyand F.	July 21, 1967
Baltimore City	
Brown, Webster H.	May 5, 1967
Daniels, Thomas F.	June 3, 1967
Dodson, Claude C.	May 20, 1967
Drozd, Joseph	November 28, 1967
Flippin, Eugene L.	March 17, 1967
Foster, Herbert M.	November 26, 1967
Goldberg, Victor	September 18, 1967
Hart, Jeremiah A.	March 26, 1967
Hogan, John F., Sr.	November 26, 1967
Karns, Clyde F.	August 17, 1967
Klimas, Albinas	January 10, 1968
Marshall, John R.	January 25, 1968
Monninger, Arthur C.	September 29, 1967
Morris, Frank K.	November 9, 1967
Morrison, J. Huff	August 13, 1967
Novey, Samuel	May 23, 1967
Prather, Perry F.	December 23, 1967
Raskin, Moses	April 20, 1967
Scheye, Henry W.	December 5, 1967
Schwartz, Daniel J.	April 15, 1967
Sherman, Solomon	August 22, 1967
Shiling, Moses S.	June 9, 1967
Smith, Fred B.	January 30, 1968
Volenick, Lee J.	September 12, 1967
Wilder, Milton J.	April 23, 1967
Wolman, Samuel	December 16, 1967
Baltimore County	
Benson, Edward H.	March 22, 1967
Howell, James G.	May 23, 1967
Dorchester County	
Wolff, Eldridge H.	December 7, 1967
Garrett County	
Baumgartner, E. I.	August 8, 1967
Harford County	
Wolbert, Frank	August 16, 1967
Kent County	
Harrison, H. H.	October 11, 1967
Joyce, Florence D.	May 2, 1967
Kester, Eugene	December 22, 1967
Montgomery County	
Barrett, Robert J.	October 2, 1967
Miller, William C.	September 26, 1967
Prince George's County	
Bosworth, Robert J.	June 9, 1967
Conant, James S.	April 9, 1967
Moyers, Waldo B.	December 10, 1967

Queen Anne's County

Hoyt, Irvin G. ..... March 31, 1967

Somerset County

Johnson, Robert H. ..... March 9, 1967

Talbot County

Robinson, John N. ..... November 29, 1967

Washington County

Dwyer, James R. ..... July 9, 1967

Affiliates

Futterman, Perry ..... December 11, 1967
Harrat, Frank T. ..... March 19, 1967
Hopkins, John V. ..... December 12, 1967

NOMINATING COMMITTEE

Mr. President and Members of the House of Delegates:

(Those elected will assume office at conclusion of the Annual Meeting 1969, unless otherwise indicated.)

President-elect

Russell S. Fisher, Baltimore
{ President-elect 1968-69 }
{ President 1969-70 }

First Vice-President

Marvin I. Mones, Silver Spring

Second Vice-President

Samuel Morrison, Baltimore

Third Vice-President

Guy M. Reeser, St. Michaels

Secretary

William A. Pillsbury, Timonium

Treasurer

Karl F. Mech, Baltimore

Councilors

Robert C. Kimberly, Baltimore, Central District (1972)
William B. Hagan, Riverdale, South Central (1972)
Manning W. Alden, Annapolis, Southern (1972)
Richard Y. Dalrymple, Westminster, Western (1972)
Robert J. Thomas, Frederick, Western (1972)
Arthur T. Keefe, Chestertown, Eastern (1968-1970)

Delegate to American Medical Association

Robert vL. Campbell, Hagerstown
(Jan. 1, 1969-Dec. 31, 1971)

Alternate Delegate to American Medical Association

Charles F. O'Donnell, Towson
(Jan. 1, 1969-Dec. 31, 1971)

Committee on Program and Arrangements

William L. Stewart, Westminster (1973)

Library and History Committee

George A. Maxwell, Rockville (1974)

Finney Fund Committee

Richard V. Hauver, Hagerstown (1974)

Board of Medical Examiners

Archie R. Cohen, Clear Spring (June 1968-June 1972)
John J. Curry, Silver Spring (June 1968-June 1969)
Gerald A. Galvin, Baltimore (June 1968-June 1971)
Karl F. Mech, Baltimore (June 1968-June 1972)

Nominating Committee

J. Morris Reese, M.D., *Chairman,* Baltimore
Manning W. Alden, MD, At Large, Annapolis
Samuel Morrison, MD, Central District, Baltimore
Henry P. Laughlin, MD, South Central District, Bethesda
Robert J. Thomas, MD, Western District, Frederick
Peter V. Thorpe, MD, Southern District, Ellicott City
Francis J. Townsend, MD, Eastern District, Ocean City

OCCUPATIONAL HEALTH COMMITTEE

Mr. President and Members of the House of Delegates:

The Occupational Health Committee, at several meetings held during the year was principally concerned with practices involving the use of free services offered by industrial groups which should rightfully be handled on a private basis.

As the result of a letter from the Pharmacy Liaison subcommittee, the problem of patients requesting prescriptions from physicians for larger quantities than normally prescribed so that they could be purchased at wholesale cost through industrial dispensaries was discussed. Any such complaint will be brought before this committee, and the Pharmacy liaison Subcommittee was so notified.

Discussion was also held regarding the practice of industries sending prospective employees to State or City Health department clinics or to the TB Association for pre-employment chest X-rays. It was moved and passed:

"The Occupational Health Committee of the Medical and Chirurgical Faculty of Maryland supports the principle that industry requiring pre-employment chest X-rays should be encouraged to contract with a private radiologist whenever possible. The Health Department and the Maryland Tuberculosis Association should discourage the use of their facilities by industry for pre-employment X-rays where it is felt that such an arrangement with a private radiologist is feasible."

After some discussion on company policies in determining loss of hearing of employees, it was agreed that no hearing tests should be given except by a technician who has had specific training in audiology.

A final dinner meeting was held, at which time Lomax Wells, MD was guest speaker. Dr. Wells is Medical Director of the C. & P. Telephone Companies and Chairman of the AMA Council on Occupational Health.

Respectfully submitted,

John R. Davis, MD, *Chairman*
Samuel N. Bacon, Jr., MD
Timothy D. Baker, MD
William F. Cox, III, MD
Walter E. Fleischer, MD
Herman J. Halperin, MD
Donald J. Roop, MD
S. Jack Sugar, MD
Arthur T. Hall, Jr., MD
Henry L. Wollenweber, MD

POLICY AND PLANNING COMMITTEE

Mr. President and Members of the House of Delegates:

Only one meeting of the Policy and Planning Committee has been held since the last Faculty Annual Meeting. This was in October, 1967, and was devoted to a general discussion of the Regional Medical Program and its plans for the future.

Medical Manpower needs were also discussed, as well as the proposal for a third medical school in Maryland.

The costs of medical care also came in for same comments and whether or not the group practice of medicine would really result in lower costs for medical care. No conclusions were reached in this regard. The Committee recommended to Council, which approved the suggestion, that a sum of up to $1,000 per year be appropriated for the purpose of preparation of histories of all component societies, until such histories were written for all components. This amount was included in the 1968 budget and it is hoped that a start can be made on this project this calendar year.

Consultations have been started with the Maryland Historical Society to ascertain whether any of the documents in the Faculty's possession can be placed on permanent loan with the Historical Society thus being made available for research purposes, being properly catalogued and adequately stored for posterity. No conclusions have been arrived at as yet.

The Committee noted with sorrow the death of its chairman during the year, Eldridge H. Wolff, M.D., of Dorchester County.

The Committee has no specific recommendations for consideration at the Annual Meeting of the Faculty.

Respectfully submitted,

ELDRIDGE H. WOLFF, MD, *Chairman* *
J. THOMPSON B. AMBLER, MD
CHARLES BAGLEY, III, MD
NEVILLE A. BARON, MD
A. N. BARR, MD
LEON W. BERUBE, MD
THOMAS V. CRAIG, MD
JOHN M. CULLER, MD
GEORGE E. GROLEAU, MD
FREDERICK J. HATEM, MD
WILLIAM A. HOLBROOK, MD
ARTHUR T. KEEFE, JR., MD
DONALD A. KNIGHT, MD
HERBERT H. LEIGHTON, MD
WILLIAM H. MOSEBERG, MD
LESLIE L. MOULD, MD
ROLANDO A. NAJERA, MD
HAROLD B. PLUMMER, MD
J. THOMAS SCHNEBLY, MD
JOHN R. SMITH, JR., MD
HUGH W. WARD, MD
WILLIAM A. WILLIAMS, MD
ARTHUR O. WOODDY, MD
RICHARD D. BAUER, MD
RUSSELL S. FISHER, MD
KARL F. MECH, MD
WILLIAM A. PILLSBURY, MD
JOHN F. SCHAEFFER, MD
ARTHUR G. SIWINSKI, MD
J. MORRIS REESE, MD
JAMES F. MCCARTER, MD
JOHN T. LYNN, MD
PETER CAPURRO, MD
JULIUS LOEBL, MD
LAWRENCE M. SERRA, MD
CHARLES SPENCER, MD
JAMES P. JARBOE, MD

* deceased

COMMITTEE ON POSTGRADUATE EDUCATION, PREVENTIVE MEDICINE, AND PUBLIC HEALTH

Mr. President and Members of the House of Delegates:

This large Committee, which is the whole of many working parts, held five meetings during the year, in addition to which the multiple subcommittees had numerous sessions. There are presently eleven subcommittees each of which has been most active during the year. Since last report, the Committee agreed to disband the Subcommittee on Aging as this problem is being discussed by several other groups on which the Faculty retains representation. A Subcommittee on Airport Medicine was added, to delve into the medical problems unique to airports and the Subcommittee on Diabetes was reactivated. Several of the subcommittees have appointed Ad Hoc Committees to discuss and recommend solutions on specific problems which have occurred during the year.

A special subcommittee was appointed to organize a symposium for the physicians of Maryland and surrounding states which will be held in November 1968. The title of the symposium will be "The Twentieth Century Adolescent." This will be sponsored by the Medical and Chirurgical Faculty and a number of specialty groups throughout the Maryland area. The symposium is being supported by funds from Geigy Pharmaceutical Company.

As is apparent from the reports of the activities of the many subcommittees this has been a most eventful year for the Committee and one during which I have personally been proud to serve as Chairman. The efforts of the dedicated individuals serving on the parent committee and the subcommittees have been responsible for the many successful seminars and educational projects engaged in during the past year. The Chairmen of each of these groups and the members serving with them have my deepest appreciation for the work that has gone into making this a productive year for the Committee on Postgraduate Education, Preventive Medicine, and Public Health.

Subcommittee on Airport Medicine: Only one meeting of this group has been held to date at which an outline for future activities was drawn. It was agreed that the purpose of the Subcommittee will be to make recommendations on the medical needs of airports, but it is understood the Subcommittee does not have the power to implement such recommendations. A major function of this group will be an effort to advise on medical services at Friendship Airport, and develop policies for smaller airports as well. It was pointed out that Friendship presently does not have a physician on duty, nor is an ambulance on the premises, although both are available from nearby areas. A six-point program of activities for this group was formulated including offering assistance to other health agencies in a study of the needs for medical facilities at Friendship, and letting aircraft organizations know of the existence of the Subcommittee and its availability for consultation.

Subcommittee on Alcoholism: One of the long time hopes of this Subcommittee was fulfilled during the past year with the opening of the detoxification unit at Provident Hospital. A motion was approved commending Addison Pope, MD, Regional Director of Mental Health for Baltimore City, for the part he played in having this unit established and encouraging his efforts to interest other general hospitals in establishing the same type treatment facility.

At the request of the Governor, the Chairman of the Subcommittee met with representatives of other organizations and helped draft a bill which would remove public drunkenness from the criminal code of Maryland and would establish treatment facilities for alcoholics. This bill was submitted to the General Assembly for its consideration, but it is felt that funds are not forthcoming to implement the legislation if enacted.

Funds were requested and received from the Faculty's Educational Fund to purchase 500 copies of the "Manual

on Alcoholism" published by the American Medical Association. This will be distributed free to members of the Faculty upon request.

A highly successful one-day seminar for physicians on the "Treatment of Alcoholics" was held at Mount Wilson State Hospital on March 7. This was co-sponsored by the Faculty, the State Department of Mental Hygiene, and the Batlimore Area Council on Alcoholism. Speakers included Ruth Fox, MD, and Marvin Block, MD, both of whom are renowned for their treatment of alcoholics. Expenses for both speakers were paid by Ayerst Laboratories. Maxwell Weisman, MD, chaired an Ad Hoc Committee which planned the program.

Subcommittee on Cancer: This Subcommittee has been studying the feasibility of establishing a central cancer registry in Maryland. After much consideration, a recommendation was made that such a central registry be established in the Baltimore City area, and that all medical personnel throughout the State have access to the information collected. This was approved by the Faculty Council after it was amended to state that this would be a *voluntary* registry.

Another recommendation submitted by this Subcommittee was that the Faculty go on record as desiring to establish workshops for medical personnel for the detection of cancer. This was tabled by the Council pending further information.

Child Welfare Subcommittee: Among the recommendations originating from this Subcommittee which were approved by the Faculty Council was a policy statement recommending that an educational program be formulated in the public school systems throughout the State for pregnant girls.

An Ad Hoc Committee to Consider PKU Legislation was appointed and submitted its report to the Council. The Committee after several meetings, felt that although there was strong feelings against this legislation as it tended to regulate the practice of medicine, and two amendments to the present law were suggested, little could be done at present in the way of repealing this law. The report was adopted by Council and published in the Maryland State Medical Journal in the hope that in the future the physicians in Maryland would become more concerned with the legislation being introduced in the State Legislature so that no law of this type would be enacted in the future without action by the medical community.

The Subcommittee became interested in the lack of facilities for emotionally disturbed children in an emergency situation. Letters were written to various state officials requesting information and to the Committee on Emotional Health requesting that it also study the problem in depth. It was learned that facilities are in the planning stage at Springfield State Hospital and two other facilities are planned for the Baltimore Metropolitan area and the Washington, D.C. Metropolitan area.

Although the Mass Measles Campaign conducted last spring was quite successful, a number of children remained susceptible to the disease. A "Mop-Up" program was endorsed by the Subcommittee and is presently being conducted through the State School System by the Department of Health. It is believed that when this campaign is completed, measles will be practically eliminated as a dangerous factor in childhood.

The Subcommittee also considered a policy statement made by the American Academy of Pediatrics recommending that the Mumps Vaccine not be used on all children but recommending its use under specific conditions. The approval of the statement is pending action of the Faculty Council.

Chronic Respiratory Diseases Subcommittee: At the Recommendation of this Subcommittee, A. Murray Fisher, MD, was nominated by the Faculty to serve on the Air Pollution Control Council of the State Health Department. Dr. Fisher was appointed by the Governor to this post and was subsequently elected chairman.

Much discussion was held on the recommendations included in the report of the Governor's Committee on Tuberculosis Control. The recommendations concerning City Hospitals, although of concern to the Subcommittee, Council felt should be considered first by the Baltimore City Medical Society. A suggestion has been sent to the Baltimore City Medical Society in this regard. Further study will be given the report in the future.

Air pollution has been a main concern of the Subcommittee and the Chairman has attended local and Statewide meetings on the Subject. A policy statement on Air Pollution Control was recently adopted by the Faculty Council at the suggestion of this Subcommittee.

The Council has also approved co-sponsorship of a seminar on respiratory diseases. Other sponsors of this statewide seminar will be the Maryland Tuberculosis Association, the Maryland Academy of General Practice, the United States Public Health Service, the Maryland Thoracic Society, and the State Department of Health.

Subcommittee on Continuing Medical Education (MEDIC): The Subcommittee has prepared and presented an increased number of programs via the network during the past year. In addition to the regularly scheduled Friday Noon Lectures on various topics, Grand Rounds presentations on Pediatrics, Neurology, and Medicine have been carried from both The Johns Hopkins Hospital and the University of Maryland Hospital to physicians throughout the State. The Joint Anesthesia Study Committee of the Baltimore City Health Department and the Baltimore City Medical Society have produced its monthly meetings on the network, and several programs have been presented by and for nursing personnel and public health personnel. The network has also been used by the Maryland Obstetrical and Gynecological Society to produce one of its programs.

A new capability has been added to the network this year, by which a regular telephone call can be connected to the circuit through the Faculty switchboard. This has permitted several speakers to remain in their offices in other states and present lectures to the MEDIC audience. In one case the Baltimore City Medical Society was not forced to cancel one of its meetings because the speaker was hospitalized. The speaker gave his talk over the telephone to the audience assembled in the Faculty building. This has also allowed Kent General Hospital in Dover, Delaware to participate in MEDIC programs by paying the cost of the telephone call and an additional amount for administrative costs. Contact can now be made with anyone in the Faculty building through connection of the MEDIC network with any extension on the switchboard. This provides for easier access to the Library by physicians in outlying areas.

The network now includes 34 hospital locations, plus the Faculty office, the State Health Department, the Hospital Council of Maryland, Inc. and the Harford County Health Department. The Harford County Health Department like the hospital in Dover, joined the network at its own expense.

Several projects are in the process of being planned for the coming year, such as replaying of tapes of the programs at stated times other than Friday Noon for physicians who are unable to attend at that time. Programs for House Staffs will also be incorporated in the schedule. Two Ad Hoc Committees have been appointed to formulate programs for both House Staff and physicians in private practice.

The Subcommittee was asked by the Council to reconsider the MEDIC network financing and to look into the possibility of supporting the network by funds obtained from sources other than the Faculty Educational Fund. The Subcommittee met on two occasions and the members polled their individual hospital staffs to obtain opinions. The decision was reached to make every possible effort to continue the network. It was felt that the network was of inestimable value to the physicians in outlying areas and could be of increasing importance to the medical community in the near future.

Contact has been made with the United States Public Health Service and with pharmaceutical companies to obtain financial commitments for continuation of the network while leaving control of programming in the hands of the Faculty. Interest has been shown in both areas, and it is hoped that support will be forthcoming from at least one of these sources in the near future.

The Committee on Postgraduate Education, Preventive Medicine, and Public Health, therefore, recommends that the House of Delegates approve the following:

> **The MEDIC network should be continued with supporting funds being provided by either a grant from the United States Public Health Service or drug companies, payable to the Medical and Chirurgical Faculty. The control of the network will remain with the Medical and Chirurgical Faculty, the State Health Department, and the local hospitals. Staff time would be provided on the same basis as is presently done, by the Faculty and the State Health Department.**

Subcommittee on Diabetes: Under the chairmanship of DeWitt E. DeLawter, MD, this subcommittee became rejuvenated this year, and participated in the Diabetes Detection Drive. Detection centers were set up at the Fifth Regiment Armory and at the Civic Center in Baltimore City, while Dreypak campaigns were conducted in the counties. The Subcommittee plans to formulate criteria of approach to various groups such as large industries, nursing homes, and penitentiaries, to conduct diabetes testing on a regular basis.

Plans are presently being made for Diabetes Detection campaigns to be held in November 1968.

Subcommittee on Maternal Welfare: This Subcommittee has had to deal with the important problem of updating the Maryland abortion laws during the past year. A special Ad Hoc Committee was appointed during the summer months to study the problem and make recommendations as to the stand of the medical community on this subject. The Committee considered the problem carefully and its report was submitted to and approved by the House of Delegates at its session in September 1967. Following this approval and as a condition of it, it was necessary to appoint another Ad Hoc Committee to Formulate Guidelines for the Performance of Therapeutic Abortion for hospitals and physicians throughout the State. This group met several times and formulated guidelines which were approved by the Faculty Council and distributed to the legislators for information. The intent is to eliminate therapeutic abortion from the criminal code of Maryland and place the performance of abortion under the Medical Practice Act.

The Subcommittee has become active in the area of perinatal morbidity and mortality and has met with members of the Child Welfare Subcommittee to formulate an educational program for physicians on this subject.

The members of the Subcommittee have also attended meetings of Component Medical Societies presenting programs on maternal welfare.

Subcommittee on the Medical Aspects of Sports: A Seminar on the Medical Aspects of Sports was held in cooperation with the Catonsville Community College last July. The program was aimed at educating trainers and coaches of secondary schools and colleges throughout the State, and was overwhelmingly successful. A repeat of this type seminar has been approved by the Council and will be held this summer.

The Subcommittee gave its attention to preparing a standard physical examination form and guidelines for use by students who wish to participate in athletics in schools. Hopefully this will be adopted by the State Board of Education and distributed through the school system. This will be used by family physicians as a guide when making determination of whether a child should be allowed to participate in competitive sports.

Speaker's Bureau Subcommittee: A Speaker's Bureau for medical societies and paramedical groups has been established and a few requests have been received and satisfactorily accommodated.

Subcommittee on Traffic Safety: This Subcommittee again concerned itself mainly with attempting to find ways and means of obtaining passage of necessary traffic safety legislation. Many meetings were devoted to discussion of various bills which were introduced in the General Assembly. Among these was a Reportable Disease law which would give the Medical Advisory Board of the Department of Motor Vehicles the authority to determine the listing of diseases and conditions which physicians would be required to report. A bill bringing the visual acuity requirements in Maryland up to presently recommended standards was also supported by this group as was a bill which would set standards for the licensing of ambulance drivers and attendants.

The "Implied Consent" bill remains the most necessary piece of legislation in the view of this Subcommittee. Several versions of this bill were introduced in the State Legislature during the past session and final disposition of them can be learned from the *Assemblymen* produced by the Faculty office.

Plans are now being made to coordinate several groups interested in traffic safety in the hope that funds can be obtained to support an intensive publicity campaign urging the passage of necessary legislation. This campaign would ideally begin this summer and continue throughout the year reaching a peak by the next session of the State Legislature. A seminar for representatives of various groups will be held at the Faculty building on May 6, 1968 to begin implementation of this plan.

Respectfully submitted,

John Whitridge, Jr., MD, *Chairman*
Ruth Workman Baldwin, MD
Robert G. Chambers, MD
H. Garland Chissell, MD
John B. De Hoff, MD
Dewitt E. DeLawter, MD
Robert E. Farber, MD
Marion Friedman, MD
Karl M. Green, MD
Lewis P. Gundry, MD
Frederick J. Heldrich, Jr., MD
John H. Hirschfeld, MD
D. Frank Kaltreider, MD
Milton B. Kress, MD
Julius Loebl, MD
William J. Peeples, MD
Joseph B. Workman, MD

SUBCOMMITTEE ON AIRPORT MEDICINE: Julius Loebl, MD, Chairman; Donald Barrick, MD, Kermit P. Bonovich, MD, James E. Toher, MD, John B. De Hoff, MD.

SUBCOMMITTEE ON ALCOHOLISM: Lewis P. Gundry, MD, Chairman; Conrad Acton, MD, Edmund G. Beacham, MD, John R. Davis, MD, Maureen Henderson, MD, John H. Hirschfeld, MD, Irene L. Hitchman, MD, Frank L. Iber, MD, Isadore Kaplan, MD, Harry F. Klinefelter, MD, Kenneth Krulevitz, MD, Abraham M. Schneidmuhl, MD, Maxwell N. Weisman, MD.

AD HOC COMMITTEE TO PLAN ALCOHOLISM SEMINAR: Maxwell N. Weisman, MD, Chairman.

SUBCOMMITTEE ON CANCER: Robert G. Chambers, MD, Chairman; Cyrus L. Blanchard, MD, Fernando G. Bloedorn, MD, Elizabeth G. Brings, MD, Earl C. Clay, Jr., MD, John B. De Hoff, MD, Louis E. Goodman, MD, Samuel Lumpkin, MD, Howard W. Jones, Jr., MD, Conrad G. Julian, MD, George A. Maxwell, MD, Alan C. Woods, Jr., MD.

SUBCOMMITTEE ON CHILD WELFARE: Karl M. Green, MD, Chairman; Raymond L. Clemmens, MD, R. M. N. Crosby, MD, John A. Grant, MD, Murray M. Kappelman, MD, Richard C. Lang, MD, Joseph J. McDonald, MD, Lawrence C. Pakula, MD, Margaret L. Sherrard, MD, Benjamin D. White, MD, Charles E. Wright, MD, Robert E. Yim, MD.

AD HOC COMMITTEE ON PKU LEGISLATION: Robert E. Yim, MD, Chairman; Raymond L. Clemmens, MD, Murray M. Kappelman, MD, Joseph J. McDonald, MD.

STEERING COMMITTEE FOR IMUNIZATION PROJECTS: Karl M. Green, MD, Chairman; Raymond L. Clemmens, MD, Murray M. Kappelman, MD, Lawrence C. Pakula, MD, Benjamin D. White, MD, Robert E. Yim, MD; and the following public health officers: Robert E. Farber, MD, Daniel L. Finucane, MD, John H. Janney, MD, John Pitts, MD, Margaret Sherrard, MD.

SUBCOMMITTEE ON CHRONIC RESPIRATORY DISEASES: Milton B. Kress, MD, Chairman; Warde B. Allan, MD, Edmund G. Beacham, MD, Otto C. Brantigan, MD, Robert E. Farber, MD, A. Murray Fisher, MD, John H. Hirschfeld, MD, Meyer W. Jacobson, MD, Elliott Michelson, MD, John E. Miller, MD, William J. Peeples, MD.

SUBCOMMITTEE ON CONTINUING MEDICAL EDUCATION (MEDIC): Frederick J. Heldrich, Jr., MD, Chairman; Samuel P. Asper, MD, Edmund G. Beacham, MD, Robert O. Biern, MD, Julius Chepko, MD, Edward F. Cotter, MD, Audoberto Flores, MD, Irving R. Freeman, MD, David J. Gilmore, MD, Wilson Grubb, MD, Carl J. Houmann, MD, Frederick M. Johnson, MD, Arthur T. Keefe, Jr., MD, Thomas Mahan, MD, Albert P. Marsh, MD, Robert E. May, MD, William C. Mulford, MD, Thaddeus E. Prout, MD, Aubrey D. Richardson, MD, William Schuman, MD, George M. Simons, MD, John C. Stauffer, MD, George I. Sutherland, MD, Gerald Wagger, MD, George J. Weems, MD, Walter Welzant, MD, R. Lane Wroth, MD, Richard A. Yates, MD, John D. Yun, MD.

AD HOC COMMITTEE TO PLAN PROGRAMS FOR HOUSE STAFF: Edmund G. Beacham, MD, Chairman.

AD HOC COMMITTEE TO PLAN PROGRAMS FOR PRACTICING PHYSICIANS: Thaddeus E. Prout, MD, Chairman.

SUBCOMMITTEE ON DIABETES: DeWitt E. DeLawter, MD, Chairman; Henry V. Chase, MD, Gerald Church, MD, John B. De Hoff, MD, Seth H. Hurdle, MD, William H. Patrick, MD, Thaddeus E. Prout, MD, Julian W. Reed, MD, Charles E. Shaw, MD, Abraham A. Silver, MD, John C. Stauffer, MD, Samuel J. N. Sugar, MD, Donald O. Wood, MD.

MATERNAL WELFARE SUBCOMMITTEE: D. Frank Kaltreider, MD, Chairman; J. Tyler Baker, MD, George H. Davis, MD, Rafael Garcia-Bunuel, MD, John S. Haught, MD, Gerald B. Holzman, MD, Hugh B. McNally, MD, J. King B. E. Seegar, Jr., MD, Edwin R. Ruzicka, MD, Joseph N. Seitchik, MD.

AD HOC COMMITTEE TO STUDY THE ABORTION LAW: Joseph Seitchik, MD, Chairman; J. Tyler Baker, MD, John M. Haws, MD, John W. C. Johnson, MD, Edmund B. Middleton, MD.

AD HOC COMMITTEE TO FORMULATE GUIDELINES FOR THERAPEUTIC ABORTION: Irvin M. Cushner, MD, Chairman; J. Tyler Baker, MD, D. Frank Kaltreider, MD, Victor A. McKusick, MD, Jonas R. Rappeport, MD, Thomas C. Washburn, MD, John Whitridge, Jr., MD.

SUBCOMMITTEE ON THE MEDICAL ASPECTS OF SPORTS: John B. De Hoff, MD, Chairman; James W. Banks, MD, Robert G. Brewer, MD, William C. Duffy, MD, G. Overton Himmelwright, MD, Charles M. Henderson, MD, J. Parran Jarboe, MD, John M. Krager, MD, Edmond J. McDonnell, MD, Andrew C. Mitchell, MD, Ross Z. Pierpont, MD, Marcus Stephanides, MD, Ramsay B. Thomas, MD, Leonard Wallenstein, MD.

AD HOC COMMITTEE TO PLAN SEMINAR ON THE MEDICAL ASPECTS OF SPORTS: John B. De Hoff, MD, Robert G. Brewer, MD, John M. Krager, MD, Ramsay B. Thomas, MD.

SPEAKER'S BUREAU SUBCOMMITTEE: Joseph B. Workman, MD, Chairman.

SYMPOSIUM SUBCOMMITTEE: John Whitridge, Jr., MD, Chairman; John B. De Hoff, MD, Frederick J. Heldrich, Jr., MD, John H. Hirschfeld, MD.

SUBCOMMITTEE ON TRAFFIC SAFETY: Ruth W. Baldwin, MD, Chairman; Timothy D. Baker, MD, Solomon E. Barr, MD, Rudiger Breitenecker, MD, Kay K. Edwards, MD, Irene L. Hitchman, MD, William P. Horton, MD, Howard F. Kinnamon, MD, Paul H. Royse, MD, Robert J. Wilder, MD.

PROFESSIONAL MEDICAL SERVICES COMMITTEE

Mr. President and Members of the House of Delegates:

At the Semiannual meeting in September, 1967, the name of this Committee was changed from the Fee Schedule Committee to that shown. It is felt this better describes the proper functions and activities of the Committee.

During the past year, the Committee has met almost monthly, with innumerable subcommittee meetings held between these monthly sessions.

Much of the time has been devoted to Title 19 problems, particularly as they apply to the concept of payment of Usual, Customary and Reasonable fees to physicians for their professional services. At the May 24, 1967 session, officials from the Department of Health, Education and Welfare visited with us and provided us with much helpful information with respect to the operation of the overall program.

In June, subcommittees were formed for the purpose of working closely with State Health Department officials so as to implement all facets of the Title 19 program with as little disruption as possible.

In July, 1967, this problem was discussed with Faculty officials and the Governor's aide for health affairs. As

a result we established what was hoped to be a closer liaison with specific persons responsible for the program operation within the State Health Department.

Full minutes of all our discussions have been kept in our files and details are available to those who might wish to peruse them. It was the feeling of our Committee that attempts should be made to inform the legislators on the House Ways and Means Committee relative to the overall concept of the Title 19 program. In our attempts to do this, we had a special session in December, 1967, which most of the members of this important Committee attended. It is too early to judge whether or not such meetings will be of any benefit but we feel the session was worthwhile. One of our Subcommittees has been charged with developing the net cost of caring for Title 19 patients as opposed to the total overall cost for such patients. In other words, it is important to look at the total cost of caring for such patients. Preventive Medicine, actively practiced, could prevent some hospital admissions. Therefore, the net total cost would be lower. The Council has authorized the Committee to expend funds, if necessary, to collect data to prove this point.

In December, a special meeting was called to which representatives of the medical staffs with organized outpatient departments were invited. This was to discuss the basis on which payments for Title 19 patients receiving care from these departments should be paid. Representatives were urged to give careful consideration to this matter and negotiate appropriate arrangements with the State Health Department as promptly as possible.

The Council also authorized the Committee to commence negotiations with the Workmen's Compensation Commission for payment of physicians on the basis of Usual, Customary and Reasonable Fees. We are presently preparing a formal request for such consideration by the Commission. Still pending afore consideration by the Council at its next meeting is a request that the State Health Department be asked to make payment to physicians for professional services rendered to patients who are receiving care as in-hospital patients and in organized outpatient departments on the basis of Usual, Customary and Reasonable fees until such time as funds appropriated for this purpose are fully expended. Following this, services would be rendered and bills submitted by physicians even though it is realized that payments will not be forthcoming because of lack of funds.

At the time of this writing, the Council still has to meet and consider this proposal.

This marks the 10th year of my service as Committee Chairman. I have found this position to be an interesting, challenging, stressful, tension-producing, frustrating but rewarding experience. I feel the time has come for me to step down so that a new chairman may be appointed. I offer to my successor best wishes and the confidence that he will receive outstanding cooperation from the committee members as I have.

Respectfully submitted,

William G. Speed, III, MD, *Chairman*
Katherine H. Borkovich, MD
Pierson M. Checket, MD
Osborne D. Christensen, MD
Archie R. Cohen, MD
John R. Davis, MD
Ernest A. Dettbarn, MD
George H. Greenstein, MD
John F. Hogan, Jr., MD
Richard E. Hoover, MD
Frederick M. Johnson, MD
John H. Hornbaker, MD
Robert W. Johnston, III, MD
Watson P. Kime, MD
Alfred R. Maryanov, MD
H. Berton McCauley, DDS
Benjamin S. Miller, MD
John E. Miller, MD
William H. Mosberg, MD
Emmanuel A. Schimunek, MD
Lex B. Smith, MD
William L. Stewart, MD
Robert Thibadeau, MD
Morris J. Witzenberg, MD
Israel Zeligman, MD
Albert J. Weiss, MD
Theodore E. Stacy, Jr., MD

COMMITTEE ON PROGRAM AND ARRANGEMENTS

Mr. President and Members of the House of Delegates:

The 169th Annual Meeting, held at the Alcazar in Baltimore on April 19, 20, and 21, 1967, under the Chairmanship of James B. Brooks, MD, had one of the largest registrations of any Annual Meeting. The scientific program was well received with a better than usual attendance at the individual sessions. There were over four hundred Health Evaluation Tests given, considerably more than in any previous year. The report on the meeting, made by the representative of the Medical Exhibitors Association, after personal contact with each technical exhibitor, was the most favorable received to date. Of particular importance was the fact that the exhibitors felt there was much interest shown by the physicians attending.

The Semiannual Meeting on September 8 and 9, 1967, was held at the Diplomat Motor Hotel in Ocean City. The registration, for the first time, was over five hundred, with quite an increase in the number of physicians attending. The various specialty societies scheduled programs in conjunction with the Faculty's meeting, and it is felt this was an asset and increased the attendance. Both the banquet and the crab feast luncheon were very well attended, and many favorable comments were received, particularly regarding the luncheon.

Several innovations have been planned for the 1968 Annual Meeting on April 17, 18, 19 in Baltimore. In place of the customary Round Table Luncheon there will be a Quiz the Experts Luncheon. In principle, this will be the same but the specialty societies have been asked to sponsor tables, and a majority of the 23 tables scheduled will be so sponsored. Also, while there will be specific topics listed, an opportunity will be provided for those attending to discuss their own clinical situation or problem with the moderators.

On Wednesday afternoon and Friday morning each, there will be three papers by nationally eminent physicians. On Thursday there will be Medical Grand Rounds presented by The Johns Hopkins University School of Medicine, and Surgical Grand Rounds presented by the University of Maryland School of Medicine. In addition that day there will be papers given by prominent physicians of national reputation. It is hoped this type program will attract the senior medical students, interns, and residents, as well as the practicing physicians.

All technical exhibit space has been sold and all scientific space allotted for the 1968 Annual Meeting.

The meeting in Baltimore in April 1968 will be followed by a week-long Caribbean Cruise Convention during which there will be nine papers presented and nine medical films shown.

We express our sincere thanks to the members of the Faculty who have cooperated in making these meetings

successful. Particular appreciation is extended to the members of the Subcommittee on Health Evaluation Tests who devote many hours to arranging and processing the tests, and to the members of the Faculty staff for their efforts and extra time in carrying out the numerous details involved in these meetings.

Respectfully submitted,
THADDEUS E. PROUT, MD, *Chairman*
JOSEPH D. B. KING, MD
DEWITT E. DELAWTER, MD
ARLIE R. MANSBERGER, JR., MD
ERNEST B. NUTTALL, DDS

SUBCOMMITTEE ON EXHIBITS: Joseph D. B. King, MD, Chairman; DeWitt E. DeLawter, MD, Richard R. Crane, Sheldon Friedman.

SUBCOMMITTEE ON HEALTH EVALUATION TESTS: Selvin Passen, MD, Elijah Saunders, MD, Harry G. Randall II, MD, William E. Peterson, MD, John E. Adams, MD, Robert L. Cavenaugh, MD, Robert E. Cranley, Jr., MD, William J. Hicken, MD, Watson P. Kime, MD, W. Bradley King, Jr., MD, Robert G. Lancaster, MD, Lawrence F. Misanik, MD, John V. Petrucci, MD, James E. Taylor, Jr., MD, Edward L. Sherrer, Jr., MD, Beverly E. Hyde, MD, Dorothy Hartel.

PUBLIC RELATIONS COMMITTEE

Mr. President and Members of the House of Delegates:

At its several meetings the Public Relations Committee dwelt on a number of projects and questions which have to do with the public's image of the physician.

Chief among its new programs is a mail-in campaign by which patients would be made more aware of the role of the Medical and Chirurgical Faculty in Maryland; the physician would be assisted in disseminating meaningful information to his patients without loss of time, and the patient, in turn, would benefit from authoritative information on his condition, helpful to him and available for easy reference at any time.

Members desiring to take part in this program are furnished with a supply of postal-size cards, addressed to the Faculty, requesting informative material on certain physical conditions. These patients would in turn receive this material as a part of a pilot program of information and education with the AMA pamphlet emanating from the Faculty.

The Public Relations committee also unanimously endorsed the annual sponsorship of Medical Assistants' seminars, which have been enormously successful. It has also been investigating the proper form for a yellow page listing in the Metropolitan Baltimore telephone book to inform the public that it may call the Faculty for assistance in locating a physician. The council adopted a policy in this regard.

Assistance was rendered the University of Maryland chapter of the Student AMA (SAMA), a group composed of 460 out of a student enrollment of 540.

Respectfully submitted,
ROBERT B. GOLDSTEIN, MD
MANNING W. ALDEN, MD
EARL M. BEARDSLEY, MD
DAVID S. CLAYMAN, MD
JAMES M. HITZROT, II, MD
WALTER E. JAMES, MD
BERNARD GORDAN, DDS
E. RODERICK SHIPLEY, MD
MRS. PERCY H. SUTLEY
WILLIAM WEGLICKI, MD
RICHARD A. YOUNG, MD

REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your Reference Committee met on Wednesday, March 13, 1968, to consider the five resolutions introduced by individual members as well as by three component medical societies. An unusually large number of persons was in attendance at our meeting and full discussion was entered into by all. As usual, *the motions made will be on the resolution itself.*

Resolution 1A/68

Submitted on: May 26, 1967

Introduced by: Prince George's County Medical Society

Subject: Condemning Attempts by Insurance Carriers to Determine Qualifications of Physicians; and Requesting That Such Carriers Amend Their Regulations to Prevent This

Whereas, Maryland Medical Service, Incorporated, indicates in its Participating Physicians, Manual, at page 26 (Rev. 2–66) that benefits will be available to its subscribers for diagnostic X-ray services only when such services are performed by physicians conforming to certain criteria established by Maryland Medical Service, Incorporated; and

Whereas, The proper practice of medicine requires the exercise of all of a physician's skills and qualifications; and

Whereas, The condoning of such regulation of medical practice by economic means may lead to further propagation of such restrictions, which are contrary to the best interest of the patient; and

Whereas, Such restrictions are not imposed upon Maryland physicians by licensure; now, therefore, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland condemns any attempt by any insurance company to determine for its subscribers which duly licensed physician is qualified to perform what medical procedure and requests that all insurance carriers doing business in this State amend their regulations accordingly.

This resolution is identical to a resolution considered at the Annual Meeting, 1967, and rejected by the House of Delegates at that time. The material contained in the Reference Committee report at that time has not changed and is worth repeating again.

"On April 28, 1959, the Council of the Faculty, in consultation with Maryland Medical Service, Inc., (Blue Shield) and the Maryland Radiology Society, took the following action:

(1) *Specific Specialty:* The doctor confining his practice to a specific specialty (excluding general surgery, internal medicine and general practice) will be paid for diagnostic X-rays within the confines of such a specialty (example—orthopedics).

(2) *General Surgery:* The doctor confining his practice to general surgery will be paid for diagnostic X-rays necessary in emergency traumatic cases.

(3) *Internal Medicine:* (a) the doctor confining his practice to general internal medicine will be paid

for diagnostic X-rays of the chest; (b) the doctor confining his practice to a *sub-specialty of internal medicine,* such as thoracic diseases, joint diseases, or gastroenterological diseases, will be paid for diagnostic X-rays within the confines of such a sub-specialty.

(4) *General Practice:* The doctor in general practice will be paid for diagnostic X-rays necessary in emergency traumatic cases and chest.

(5) In rural areas and small communities where a radiologist is not available within approximately ten miles, consideration of payment for diagnostic X-rays will be given on an individual doctor basis. In most instances, this would be only for the diagnostic X-rays necessary in emergency traumatic cases.

ACTION: On motion duly made, seconded and carried, it was voted to approve the provision of Diagnostic X-ray coverage as suggested by the Maryland Medical Service, Inc., as amended by the above policy modifications, under Blue Shield policies only.

"On November 18, 1965, the Council reaffirmed that this policy remain in effect. From this background information, it can be seen that little, if any, hardship is being developed by this policy determination.

"In testimony heard before the Committee, it was ascertained that Blue Shield would find it extremely difficult to properly police the indiscriminate taking of X-rays.

"We are in general agreement that third party carriers should not, *on their own,* establish criteria for payments of physicians under regulations issued by them. The criteria involved and mentioned in this resolution was developed in cooperation with the Faculty, representing the medical profession. It is not known of any other instance where Insurance Companies have developed such restrictions *on their own.* If any difficulties arise in this connection, they should be channeled through the Faculty's Mediation Committee.

"We see no reason, therefore, to change the established policy in this regard."

Your Reference Committee recommends that this resolution *NOT* be adopted.

Resolution 2A/68

Submitted on: February 7, 1968

Introduced by: Baltimore County Medical Association

Subject: Endorsement of retention of the Present Board of Post-Mortem Examiners as a Separate State Government Agency

Whereas, The Medical and Chirurgical Faculty of the State of Maryland in special session held in 1939 adopted a report of a special committee that recommended the establishment by state law of the Department of Post-Mortem Examiners; and

Whereas, This report gave, among other reasons for such a separate department, that its composition consisting of the Professor of Pathology at The Johns Hopkins University School of Medicine, the Professor of Pathology at the University of Maryland School of Medicine, the State Health Commissioner, the Baltimore City Health Commissioner and the *Superintendent of the Maryland State Police, would be non-political; and

Whereas, The State Legislature in 1939 adopted such a law which has, with minor amendments, served the citizens of Maryland well; and

Whereas, The Governor's Task Force to Study the Modernization of the Executive Branch of the State Government (Curlett Commission appointed by Gov. Tawes) has recommended that the function of the Department of Post-Mortem Examiners should be delegated to the Health Department; and

Whereas, The Report of the Committee on the Executive Branch of the Constitutional Convention indicated that the Executive Reorganization of the State Government would not require the Department of Post-Mortem Examiners to be absorbed into another agency of the State Government and that it could continue to operate as it has in the past; and

Whereas, Any change in the present organization of the Department of Post-Mortem Examiners would work to the detriment of the State in its capacity of ascertaining the cause of unexplained deaths, or deaths as a result of violence, suicide, casualty or suddenly when in apparent health or when unattended by a physician or in any suspicious or unusual manner; therefore, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland goes on record as strongly supporting the principle of the Department of Post-Mortem Examiners remaining an autonomous agency of the State Government and that it not be absorbed into another agency.

*In the original report this was the Attorney-General but this was later changed to read Superintendent of the Maryland State Police.

The information contained in the resolution is self-explanatory and has all been verified as being accurate.

We heartily concur that the Department of Post-Mortem Examiners should remain as an autonomous agency. We believe that this agency has served the citizens of Maryland well and that it has reached a position of not being excelled, anywhere in the United States.

We believe, also, that its absorption into another agency or department of State Government would serve no useful purpose and would, in all probability, dilute its strength and effectiveness.

It is recommended, therefore, that Resolution 2A/68 BE ADOPTED.

Resolution 3A/68

Submitted on: February 16, 1968

Introduced by: Montgomery County Medical Society

Subject: Authorizing the Council, in Special Instances, to Waive Bylaws Requirements That Physicians' Defense Be Granted Only If Dues Are Paid by January 31 of the Year in Which the Event Occurred.

Whereas, The Bylaws, as amended, make it mandatory that the benefits of Physicians' Defense be denied any physician failing to pay his dues and assessments by January 31st each year; and

Whereas, Manifest injustice may result from a strict application of the Physicians' Defense section of the present Bylaws; and

Whereas, The ends of justice and fair play may be better served by authorizing the Council of the Medical and Chirurgical Faculty to waive the deadline of January 31st in individual cases for good and proper cause; therefore be it

Resolved, That the House of Delegates declares it to be Faculty policy, and hereby authorizes the Faculty Council, for demonstrated good cause in individual instances to waive the mandatory cut-off date for eligibility for Physicians' Defense.

The effect of this resolution, if adopted, would be to allow the Council to suspend a Bylaw. A Bylaw may not be suspended unless the provision for doing so is contained in the Bylaws themselves.

Accordingly, this resolution is out of order and the Reference Committee did not consider it.

Our Parliamentarian advises us that if the Committee had considered it, the President would have been required to rule it as being out of order, because even if it were adopted it would be null and void.

Because of the form in which this resolution was presented, it could not be referred by the Executive Secretary to the Bylaws Committee. By the time the Reference Committee had met it was too late for consideration of the Bylaws Committee in sufficient time for action at the Annual Meeting.

In spite of this the Committee gave consideration to this proposal and does not feel that it is an appropriate recommendation.

The Reference Committee, therefore, recommends that this resolution be ruled out of order and that it be referred to the Bylaws Committee for its consideration and report to the House of Delegates at the September, 1968, meeting.

Resolution 4A/68

Submitted on: February 21, 1968

Introduced by: Richard A. Sindler, MD, and 29 other members of the Baltimore City Medical Society

Subject: Reversal of Faculty Position Taken in 1962 Regarding Incorporation of Self-employed Persons

Whereas, Incorporation of self-employed persons is an established practice in 35 States at this time; and

Whereas, The right of an individual physician to incorporate his medical practice in Maryland, when deemed personally desirable, should not be denied; now, therefore, be it

Resolved, That the membership of the Medical and Chirurgical Faculty of the State of Maryland endorses and supports the principle of incorporation of self-employed persons at the option of the individual; and be it further

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of Maryland reverse its previous position taken in September, 1962, and now favorably endorse the incorporation of self-employed persons.

This resolution would ask that the House of Delegates reverse a policy adopted in 1962 with respect to the incorporation of self-employed persons.

The report of the Policy and Planning Committee adopted in 1962, contained the following information:

"Incorporation of Physicians

"There are two ways in which incorporation proposals can be accomplished:

I. In the U.S. versus Kintner, a Montana Association of Physicians was held to have sufficient attributes to permit its classification as an association taxable as a corporation. However the IRS states that the determinations as to whether or not criteria are met depend on State Laws. In Maryland the Uniform Partnership Act would assign to associations characteristics incompatible with the requirements established by the IRS. If this means is used, several facts are apparent:
   1. The group would have to have assurance that the Board of Medical Examiners would not prosecute for violation of the Medical Practice Act.
   2. The IRS only recognizes the Kintner decision in the Ninth Circuit Court District and in fact recent legal cases have suggested that the IRS would not accept this decision.
   3. The IRS can litigate at any time within three years, and if this happened and the IRS won after an extensive litigation, the funds invested in pension plans, etc. would be lost.

II. The Maryland State Corporate Law could be changed to allow the Corporate Practice of Medicine. To accomplish this either a new statute would have to be drafted or the present Corporate Law amended. In either case it would have to be lobbied through the Legislature with the risk of incurring unfavorable publicity. If the Legislature allowed this then a *guinea pig Association* would have to be formed and its format submitted to the IRS for a ruling. If an unfavorable ruling were obtained then litigation would have to be resorted to.

"COMMENTS

In both of the above, a group of physicians would have to meet the criteria for qualifications as a corporation laid down by the IRS and these include:

1. Limited liability.
2. Continuity of life.
3. Centralization of management.
4. Free transferability of interest.

"These criteria will face scrutiny by the IRS and there is grave doubt that these could be actually carried out by an association of physicians without impairing many of our cherished precepts, namely:

The responsibility of an individual physician to his patient, and

The possibility of a malpractice suit involving all members of an association to the extent of corporation assets.

"It is noteworthy that in January 1962, the Maryland State Bar Association went on record as opposing any legislation which would permit incorporation of lawyers although they took no stand on other professions. It is understood that the Maryland State Dental Association has also adopted a similar stand.

"The Committee feels as follows:

1. The incorporation of physicians by any means would be only for the effect of tax advantage. This advantage, even if obtained, could be wiped out by new legislation at any time.
2. The medical profession is not a business. Personal responsibility for one's own act is a characteristic of professional status and this would be destroyed by resorting to such tactics to obtain a tax advantage which may be transient.
3. One of the greatest concerns of medicine today is the constant inroads made on the concept that only a physician may practice medicine. If the Maryland Practice Act is amended to allow the corporate practice of medicine, we have very little defense against other corporations hiring physicians and practicing medicine.
4. If the incorporation of physicians were approved, the economic factors involved might well force many solo practitioners into group practice—a further infringement of the rights of physicians.

"RECOMMENDATIONS:

"THE COMMITTEE IS UNANIMOUSLY OF THE OPINION THAT THE MEDICAL AND CHIRURGICAL FACULTY SHOULD NOT SUPPORT ANY SUCH LEGISLATION AND SO RECOMMENDS TO THE HOUSE OF DELEGATES.

"FURTHER IT FEELS THAT THE FACULTY SHOULD NOT SUPPORT ANY PHYSICIAN OR GROUPS OF PHYSICIANS WHO ARE SEEKING TO CHANGE THE MEDICAL PRACTICE ACT WITH REGARD TO TAX ADVANTAGES."

The Committee heard many persuasive arguments with respect to adoption of this resolution and reversal of the House action in 1962. However, many questions remain unanswered, primarily from a legal standpoint.

Your Reference Committee, therefore, recommends that Resolution 4A/68 be referred to the Policy and Planning Committee from whence the 1962 report originated, for study and report to the House of Delegates at the Semiannual Session, 1968. In making such a recommendation it is understood that all interested parties should be given an opportunity to be heard.

Resolution 5A/68

Submitted on: February 21, 1968

Introduced by: Joseph H. Hooper, Jr., MD, and Harry F. Klinefelter, MD, and 28 other members of the Baltimore City Medical Society

Subject: Urging Physicians to Charge Their Usual, Customary and Reasonable Fees under PL 89–97, Title 18 of the Social Security Law; and Not to Complete Assignments in this Regard.

Whereas, Public Law 89–97, Section XVIII, Part B, of the Social Security Law, provides for payment of physicians' services through a monthly payment by the patient matched by an equal payment from the Federal Government; and

Whereas, Under new provisions of this same law passed by the 90th U.S. Congress, patients may be paid by the carrier (Blue Shield in Maryland) on presentation of a physician's itemized, NON-Receipted bill; and

Whereas, It is no longer necessary for the physician to accept an assignment in order to receive payment from those patients who do not have funds immediately available; and

Whereas, One system of payment will serve to aid the carrier in processing claims; and

Whereas, Continued acceptance of assignments can easily lead to the setting of physicians' fees by the Federal Government; now, therefore, be it

Resolved, That the physicians of Maryland be encouraged not to accept assignments but to charge their usual and customary fees, allowing their patients to submit itemized bills or statements to the carrier for payment to the patient.

In 1965, at the Semiannual Session, a policy was clearly enunciated that physicians, as individuals, must decide for themselves to what extent they should participate in PL 89–97, the Social Security amendments of the 89th U.S. Congress.

At the Semiannual Session in September, 1966, considerable discussion ensued about physicians charging their Usual, Customary and Reasonable fees under Medicaid, Workmen's Compensation Cases and others. At this time similar resolutions were adopted.

Your Reference Committee, therefore recommends ADOPTION of Resolution 5A/68.

In closing, we would be remiss if we did not express our appreciation to all of those who contributed by their words and deed to this report. We would also like to express our appreciation to those who came to the Reference Committee meeting and expressed their viewpoints on the resolutions under consideration.

DeWitt E. DeLawter, MD, *Chairman*
Manning W. Alden, MD
Howard F. Kinnamon, MD
Herbert H. Leighton, MD
J. Emmett Queen, MD

TREASURER

Mr. President and Members of the House of Delegates:

The 1968 General Fund budget of the Medical and Chirurgical Faculty is presented for your information and as a matter of record in accordance with the Bylaws.

ESTIMATED EXPENDITURES
1968

	Budget 1967	Actual through Nov. 1967	Budget 1968	
Auditing	$ 1,500.00	$ 1,374.85	$ 1,500.00	
Legal	5,000.00	5,830.20	5,000.00	
Contributions	700.00	350.00	700.00	A*
Fuel	2,000.00	1,428.26	2,000.00	
Gas, Electricity, Water	5,000.00	4,191.77	5,000.00	
Telephone & Telegraph	4,800.00	4,192.46	5,000.00	
Postage	5,500.00	4,799.92	6,500.00	
Household & Janitorial	1,600.00	1,530.36	1,600.00	
Property Maintenance	2,500.00	2,004.21	2,500.00	
Insurance	2,000.00	1,807.03	2,000.00	
Equipment Rental	3,000.00	2,888.14	3,500.00	
New Equipment	8,500.00	6,289.90	2,500.00	
Equipment Maintenance	1,000.00	888.83	1,000.00	
Stationery & Supplies	4,000.00	3,437.40	4,000.00	
Salaries	153,698.00	143,241.10	169,266.00	B*
Social Security	5,500.00	4,964.97	6,316.00	
Unemployment Compensation	2,000.00	329.70	2,000.00	
Employee's Insurance Program	3,000.00	2,500.66	3,000.00	
Employee's Pension Program	8,500.00	12,399.00	10,000.00	
Supplementary Hours Exp.	2,000.00	2,278.04	2,500.00	
Travel	6,000.00	4,151.06	6,500.00	C*
Printing: Committees	2,000.00	1,347.07	4,500.00	
Gov'n Bodies	2,000.00	2,790.98		
Legislation	5,000.00	4,780.58	5,000.00	D*
Library	5,000.00	1,890.70	5,000.00	E*
Journal Expense	70,000.00	84,297.24	85,000.00	
Annual & Semiannual Meetings	21,000.00	23,049.12	23,000.00	
Interest to Coggins Fund	5,500.00	5,500.00	5,500.00	
Presidential Fund	1,000.00	0	1,000.00	
Woman's Auxiliary	.....	.....	1,000.00	F*
Miscellaneous Expenses	2,500.00	3,211.00	3,500.00	G*
Total	$341,798.00	$337,744.55	$375,882.00	

* See Explanatory Notes.

ESTIMATED INCOME
1968

	1967 Through November		1968 Budget	
Dues				
Baltimore City Medical Society	$108,262.50		$108,000.00	
Counties	111,952.50		111,000.00	
Baltimore City Dental Society	1,930.00		1,900.00	
		$222,145.00		$220,900.00
Rents & Services				
Baltimore City Medical Society	$ 24,868.00		$ 25,943.00	
Board of Medical Examiners	5,270.00		6,300.00	
Maryland League for Nursing	385.00		420.00	
Med-Chi Insurance Trust	10,772.00		11,270.00	
Other	25.00		.....	
		$41,320.00		$ 43,933.00
Investments				
General Purpose		$ 4,109.43		$ 4,000.00
Medical Journal		$ 85,918.13		$ 85,000.00
Annual Meeting		$ 19,851.62		$ 18,000.00
Other		$ 6,613.43		$ 6,000.00
Total		$379,957.61		$377,833.00

EXPLANATORY NOTES ON 1968 PROPOSED BUDGET

Budgetary items for 1968 are predicated on actual cost for 1967. Only items where there is a substantial change will have explanatory notes.

A. Contributions:

National SAMA	$100.00	
Student AMA, Maryland Chapter	250.00	
National Society for Medical Research	50.00	
Miscellaneous (Maryland League for Nursing)	300.00	$700.00

B. Salaries:

Reflected in this figure are anticipated salary increments during 1968, plus offsetting amounts shown under receipts from Faculty's Insurance Trust and the Baltimore City Medical Society for services of its employees on Faculty payroll.

C. Travel:

The following items are budgeted for travel during 1968:

Professional Convention Management Association and Medical Exhibitors Association, New Orleans, Louisiana, January 2-6—One Staff Member

National Congress on Socio-Economics of Health Care, Chicago, Illinois, March 21-23—One Staff Member

Medical Society Executives Assn. (1 Day) and AMA Annual Meeting (5 Days), San Francisco, June, 1968—One Staff Member, Three Delegates, Senior Alternate Delegate

Medical Society Executives Assn. (1 Day) and AMA Annual Institute (2 Days), Chicago, Illinois, August, 1968—Two Staff Members

American Medical Association House of Delegates (4 Days), Miami, Florida, December, 1968—One Staff Member, Three Delegates, Senior Alternate Delegate

Health Quackery Conference; Legal Conference for Society Executives; Congress on Medical Ethics, Chicago, Illinois, October 2-6—One Staff Member

Journal:

State Medical Journal Advertising Bureau Meeting, Chicago, Illinois, October, 1968—One Staff Member

American Medical Writers' Assn. Meeting, Washington, D.C., September, 1968—One Staff Member

Library:

Special Libraries Assn. Annual Meeting, Los Angeles, California, May-June, 1968—One Staff Member

Medical Library Association Meeting, Denver, Colorado, June, 1968—One Staff Member

Regional Medical Library Assn., Richmond, Virginia Fall, 1968—Two Staff Members

Any travel for which the Faculty is reimbursed by the AMA or other affiliated, allied or associated groups is approved without reference to the Executive Committee.

D. Legislative:

Operation of Legislative First Aid Room	$1,000	
Distribution of Legislative Newsletter (5 issues)	2,500	
Copies of legislation	200	
Legislative representatives expenses (Travel, meals, telephone, etc.)	500	
Expenditure for Federal legislation	300	
Legal services for preparation and analysis of proposed legislation	500	
		$5,000

E. Library Expenses:

Total per Library Budget	$33,500	
Less: amount included in Salaries, fringe benefits, social security, accounts	28,500	
Library Expense of General Fund		$5,000

Journal subscriptions, books and binding are not included in the above, but are purchased out of income from specific fund for Library purposes.

Light, heat, telephone, payroll taxes, etc., are also excluded.

F. Woman's Auxiliary:

New item of $1,000.00 for assistance to the Woman's Auxiliary in its various projects has been added. A previous item of $500.00 carried in the Faculty printing budget will be deleted.

G. Miscellaneous :

Additional $1,000 added to Miscellaneous for the purpose of preparation of histories of all component societies; this sum to be used annually until such time as all component society histories have been completed.

Respectfully submitted,
KARL F. MECH, MD, *Treasurer*

UNIVERSITY OF MARYLAND MEDICAL SCHOOL CHAPTER, STUDENT AMERICAN MEDICAL ASSOCIATION

Mr. President and Members of the House of Delegates:

During the 1967-68 year, 147 new members joined the University of Maryland Medical School Chapter of the Student American Medical Association. This gives us a total membership of 465 out of a class of 540; or 91% of those eligible.

Our Chapter, in line with its previous activities, has continued to publish the *Asclepian,* chapter newspaper, on a bi-monthly basis. For the first time this year and with the financial assistance of an insurance company, the chapter published a student directory. This included a list of addresses and telephone numbers of all medical students.

In the field of career recruitment, the Chapter continued its visits to local high schools and colleges and distributed the AMA publication, *Horizons Unlimited.* In direct cooperation with the Faculty, Career Day will be held on April 27, when area high school and college students will be invited to spend a day at the Baltimore campus. The program will include a series of lectures in the morning and a tour of the campus and facilities in the afternoon. Also for the first time this year, a student faculty art show was held and paintings were displayed in the Student Union. Small cash prizes were awarded to the best three paintings as judged by several local art critics.

Two lectures on the topic, New Trends in Medical Education, were sponsored during the year. George T.

Harrell, MD, of the Hershey Medical School, spoke on New Curriculum for New Medicine; and Carroll Witten, MD, Past President of the American Academy of General Practice, talked on New Trends in Family Medicine.

For the tenth year, the Chapter mailed the SAMA evaluation forms to this year's internship class. The results, along with those of the past years, are filed by the state and are on reserve in the University Health Sciences Library.

On an administrative level, the chapter has revised and updated its bookkeeping and filing systems; and adopted a policy of having the student body vote on all national resolutions and of sending our delegates to the national SAMA convention, instructed to follow the results of the local vote.

The Chapter has instituted a policy of awarding an engraved gavel to each outgoing president and to provide certificates to others who have served on the SAMA Executive Council.

The Chapter expresses its appreciation for the continued support of the medical profession through financial grants from both the Medical and Chirurgical Faculty and the Baltimore City Medical Society. Without this financial assistance, it would not be possible to accomplish all of the objectives outlined.

Respectfully Submitted,

JOHN GELIN, *President;*
DAN FREEDENBURG, *Vice-president;*
FELIX KAUFMAN, *Secretary;*
ARTHUR WAGNER, *Treasurer.*

THE WOMAN'S AUXILIARY TO THE MEDICAL AND CHIRURGICAL FACULTY

Mr. President and Members of the House of Delegates:

This is the first time in many years that an annual report has been made to the House of Delegates by the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland. We are pleased and, indeed, honored to have the opportunity to let you know what we have accomplished and what we hope to do in the future. But first some background information about *YOUR* Auxiliary.

At the present time, there are 11 Component Auxiliary groups throughout the State which cover 13 counties and Baltimore City. Membership totals 866 through this source. We have an additional 44 "members-at-large," which group originates in counties which have no formal organized auxiliary activity.

Your Auxiliary functions by:

1. Supporting community and statewide health-related programs.

2. Conducting educational programs at secondary school and college level for recruitment of students to medicine, nursing and other, para-medical professions.

3. Raising funds for the support of health professions, student-loan and scholarship programs.

4. Helping medical student and house officer wives to understand the demands of a physician's practice; and how he can be assisted through Auxiliary activities.

5. Participating in public education programs to clarify and understand the services rendered by physicians.

6. Cooperating with similar programs undertaken through the Auxiliaries of the American Medical Association and the Southern Medical Association.

Various means of communication are utilized by the State Woman's Auxiliary to coordinate the activities of and cooperate with local, component auxiliaries. State and Regional meetings; publication of a newsletter and articles in the *Maryland State Medical Journal;* attendance of the Auxiliary President and officers at local component auxiliary meetings; each component Auxiliary representation on the Board, and many other mechanisms.

The Auxiliary members provide community services in many ways. It provides manpower to assist physicians in operation and promotion of health fairs, athletic injuries seminars, immunology and diabetic detection clinics and blood bank programs.

Subscriptions to *Today's Health* were given to local school libraries and members actively participate in the observance of Poison Control and Fire Prevention weeks. In this latter connection, the Safety Chairman of the Baltimore City Auxiliary attends all meetings of the Baltimore Safety Council. Through the Office of Civil Defense, one component auxiliary has arranged to have survival kits sent to all members.

In the interest of education, tours of mental institutions were sponsored by the Auxiliaries. Cash donations and seasonal gifts were given to mental hospitals. In addition the Day Care Center for Retarded Persons in Harford County, the Day Care Center in Cecil County, the Baltimore Psychiatric Day Center, and the Montgomery County Workshop for the Handicapped received support—both financial and by volunteer work.

The Future Nurses and Health Career Club of Maryland and its 70 high school units are sponsored by the Auxiliary. Some financial assistance is given and transportation is provided for the students to the annual and other club meetings. The Woman's Auxiliary Health Careers Chairman attends all executive committee and annual meetings, and also liaison representatives from the component Auxiliaries serve at the unit level. The students themselves provide one scholarship a year while the Auxiliary provides nine. For the first time this year the President of the FN-HC Club presented a report at the annual meeting of the Auxiliary. Allegany County, with the cooperation of the Medical Society, developed a program consisting of some 100 slides and commentary, covering every job opportunity in health fields in the local area. This program has been given in all local high schools and will be a feature of the Faculty Auxiliary's annual meeting.

Since 1956, medical students have received $16,000 in interest-free loans made available by the Baltimore City Auxiliary, while Cecil County has provided free text books to a class in medical technology.

At the 1967 Convention of the American Medical Association, James Z. Appel, MD, presented the Auxiliary with a bronze plaque in recognition of its contribution of $5,564.67 to the American Medical Association—Education and Research Foundation. This was the largest amount given by a State in the 501-1,000 membership category, marking the third consecutive year that Maryland has won this award. These monies are included in the checks presented to the Deans of The University of Maryland and The Johns Hopkins Schools of Medicine at the Annual Meeting of the Medical and Chirurgical Faculty. Funds were raised through the sale of AMA-ERF "Christmas," "In Memoriam," "In Appreciation," and "In Honor Of" cards, and through such projects as theater parties, dinners, luncheons, fashion shows, auctions and the "Doctor's Wife" rose bush.

Following the pattern of the Woman's Auxiliary to the AMA, our liaison member to the Woman's Auxiliary to the Student American Medical Association serves as a member of our Executive Board. With the hope of interesting both wife and husband in future medical

society membership, guidance on procedures and programs were given, and the homes of Auxiliary members were opened for WASAMA meetings. Financial assistance was given by the State, Baltimore City and Baltimore County Auxiliaries to meet the expense of sending delegates to the annual meeting of the Student American Medical Association Auxiliary in Detroit. The president of this group gave her annual report to the House of Delegates of our Auxiliary. Upon graduation the young people who go to *Wicomico County* as interns and residents, are met by a "Welcome Wagon" provided by the local Auxiliary and invited to its meetings.

The Committees on Legislation and International Health of the Woman's Auxiliary to the AMA have counterparts in our State. The "Legislative Round-up" is reproduced and sent to all components who are also kept informed of pertinent and pending local legislation. The Auxiliary has representation on the Board of the Maryland Medical Political Action Committee. Over 1,000 pounds of sample drugs, current medical periodicals, "johnny" coats and leper bandages were collected for shipment to underprivileged countries through AMA approved outlets.

At the annual meeting of the Woman's Auxiliary to the Southern Medical Association, Maryland received a certificate and monetary award for the best State-wide observance of "Doctor's Day."

All members are kept informed of past achievements and forthcoming events through the official newsletter, *Hygeia Filia.* Since this publication is sent to all of the 51 State Auxiliaries and all officers and chairman of the Woman's Auxiliary to the AMA, many comments and inquiries are received from distant points. A page of Auxiliary news is also published in each issue of the *Maryland State Medical Journal.*

While a substantial contribution was made in the health field, if every physician's wife had joined the Auxiliary and assumed the responsibility that goes with membership, these activities could have been extended and improved.

I wish to express my personal appreciation and that of the Auxiliary, for your giving us this opportunity to report on our activities, and also for your financial assistance during this past year.

Louise Stone, (Mrs. William S.) *President*

OCEAN CITY MEETING

MEDICAL AND CHIRURGICAL FACULTY

THURSDAY, FRIDAY, SATURDAY,

SEPTEMBER 5, 6, 7

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by John Sargeant

The Executive Committee, at its April 4, 1968, meeting took the following actions:

1. Approved the appointment of Theodore Patterson, MD, Dundalk, to serve on an Advisory Body to the Essex Community College in connection with paramedical curriculum.
2. Authorized attendance of two representatives of the Faculty at a regional legislative conference sponsored by the AMA in New York City, at AMA expense.
3. Voted to table a resolution offered by the Omaha/Douglas County Medical Society, Nebraska in connection with AMA responses to publicity on medical care costs.
4. Approved a session for key Faculty staff persons and invited guests including component executive secretaries and allied professional groups counterparts, during which ways to improve office operations and services to members would be discussed.
5. Authorized regional training sessions for office assistants and, where desired, physicians, in connection with health programs and ideas.
6. Adopted a recommendation dealing with mumps vaccine as follows:

"Until more definitive information is available with respect to duration of immunity, the Faculty does not recommend the routine use of mumps vaccine for all infants and children. In view of the potential benefits of the vaccine, its use for the following special groups of individuals should be considered if they have not had clinical mumps:

1. **Boys who are approaching puberty**
2. **Adolescent and adult males**
3. **Children living in closed institutions, perhaps in summer camps, or under other similar epidemiological circumstances.**

"Inactivated mumps vaccine or mumps immune globulin are no longer recommended for susceptible adult males who have been exposed to a person with mumps. There is insufficient data as yet on which to judge the possible value of live attenuated mumps vaccine in preventing disease following exposure."

7. Approved sponsorship of a seminar, limited to 100 members, on Physiological Aspects of Alcoholism.
8. Declined to take formal action against the appointment of Wilbur Cohen as Secretary of the U.S. Department of Health, Education and Welfare.
9. Suggested two names to the State Health Commissioner for possible appointment to a newly formed Occupational Health and Safety Advisory Board within the Department of Labor.
10. Authorized the employment of an additional staff person at the secretarial level to assist in handling the increased work load.
11. Approved renewal of sustaining membership at a cost of $50.00 in the Maryland Public Health Association.
12. Authorized the Faculty acting as a catalyst in connection with centralization of records on transplants and use of Faculty facilities to call a meeting of interested parties in this regard. This is in line with recently adopted legislation in this area.
13. Heard of discussions taking place in connection with possible computerization of Faculty membership records.

14. Submitted a revised list of names to the Governor for appointment to the Board of Physical Therapy Examiners.
15. Determined that starting with the 1968–69 year the Faculty would not be able to provide staff to operate projection and PA system equipment at specialty group meetings. All those concerned will be notified when meeting dates are being set up for the next meeting year schedule.

The Executive Committee on May 9, 1968, took the following actions:

1. Endorsed the suggestion of the Medical Advisory Board, Division of Vocational Rehabilitation, for apointment to that Board.
2. Advised an inquirer that the Faculty could not establish the policies for payment under Maryland's Medical Assistance Program, but could only "recommend" or "advise" the State Health Department in this regard.
3. Approved the principle of a Scoliosis Screening Project as proposed by the Maryland Orthopedic Society; but asked for further details before giving an unqualified endorsement.
4. Approved holding of the House of Delegates Ocean City meeting on Thursday, September 5, 1968, at 8:00 P.M. and again on Friday, September 6, 1968, at 9:30 A.M.
5. Changed the time of the Ocean City Council meeting to 2:00 P.M. on Thursday, September 5, 1968.
6. Endorsed the proposal that a special "Hopkins Day" be held the day before the 1969 annual meeting starts; with special events scheduled at the new Johns Hopkins Educational Complex; and suggested that a similar schedule be followed for the 1970 meeting using the University of Maryland Medical School facilities.
7. Heard a presentation in connection with a survey to be conducted in the Baltimore Metropolitan area on Physician utilization.
8. Approved Faculty membership in the Baltimore Museum of Art.
9. Referred to the Mediation Committee the question of third-party payor liaison on various phases of utilization review, endorsing the principle that such is a necessary function of the profession.
10. Made certain recommendations to the Council for its consideration in connection with Chiropractor activity.

The House of Delegates at its annual meeting took the following actions; On Wednesday, April 17, 1968, it:

1. Observed a moment's silence in honor of deceased members.
2. Heard resolutions of commendation for work done by members who had died during the previous year.
3. Elected various members to Emeritus category, all at the request of the Component Society involved and the Council.
4. Adopted unanimously a resolution honoring Thomas B. Turner, MD, Dean of The Johns Hopkins University School of Medicine, on the occasion of his forthcoming retirement.
5. Presented plaques to physicians who have completed tours of volunteer duty in Viet Nam as part of the AMA program of Volunteer Physicians for Viet Nam.
6. Adopted the Treasurer's and Auditor's report; and had presented to it for information the 1968 budget.
7. Adopted various Bylaw amendments.
8. Received the report of the Nominating Committee.
9. Heard a report from the President of the University of Maryland School of Medicine chapter of the Student AMA.

10. Heard a report from the President of the Maryland Medical Political Action Committee.
11. Adopted a recommendation of the Membership Committee that Bylaw amendments be drafted so that Doctors of Osteopathy who have licenses to practice medicine and surgery may be admitted to membership in Component Societies and the Faculty.
12. Rejected a recommendation of the Membership Committee that membership applications contain the words, "I hereby agree to confine my practice of medicine to scientific principles as enunciated by my peers."
13. Adopted a recommendation from the Membership Committee that the question of hospital staff membership is one for each hospital to decide; and that doctors of osteopathy should be required to meet the same standards as doctors of medicine and that the policy as established by the Joint Commission on Accreditation of Hospitals be followed in this connection.
14. Adopted a recommendation of the Committee on Emotional Health that the State Board of Health and Mental Hygiene be urged to give high priority to the establishment of a drug abuse center for Maryland.
15. Adopted a recommendation of the Committee on Postgraduate Education, Preventive Medicine and Public Health that the MEDIC network be permitted to accept grants for support of the network from drug companies, the United States Public Health Service, payable to the Faculty.
16. Adopted a recommendation of the Treasurer that the MEDIC network be continued and that sufficient funds be appropriated to the extent needed to finance the operations for the coming MEDIC year.
17. Received reports from all other Faculty Committees for information purposes.
18. Officially recognized the "yeoman service" given on behalf of the Faculty by those persons involved in legislative activity during the 1968 General Assembly session.

On Friday, April 19, 1968, it:

1. Elected officers for the various posts that were vacant.
2. Received and adopted a resolution honoring Russell S. Fisher, MD, for his service as Council chairman for the past five years.
3. Heard a report from Mrs. Louise Stone, President of the Woman's Auxiliary to the Medical and Chirurgical Faculty.
4. Extended the privileges of the floor to Mrs. H. Leonard Warres, President-elect of the Woman's Auxiliary to the Medical and Chirurgical Faculty, who discussed the concept of 100% auxiliary membership and offered a motion to accomplish this. The House voted to refer this to the Policy and Planning Committee for study and report to the House of Delegates at the Semiannual session.
5. Rejected Resolution 1A/68, dealing with a proposal that the Faculty "condemns any attempt by any insurance company to determine for its subscribers which duly licensed physician is qualified to perform what medical procedure . . ."
6. Adopted Resolution 2A/68, dealing with the maintaining of the Board of Post-Mortem Examiners as a separate state agency; and requesting that in any Executive Reorganization of the state government, that it not be absorbed into another agency.
7. Referred Resolution 3A/68 to the Bylaws Committee, inasmuch as it dealt with a change in policy that would require a Bylaw amendment and was, therefore, out of order.
8. Referred Resolution 4A/68 to the Policy and Planning Committee for study and report to the Semiannual Meeting, inasmuch as it involved a reversal of present policy dealing with incorporation of self-employed persons.
9. Adopted Resolution 5A/68 dealing with encouraging physicians not to accept assignments under Title 18, Part B (the Medicare law).
10. Adopted a resolution honoring the Executive Secretary on the completion of ten years with the Faculty.

11. Referred Resolution 6A/68 to the Reference Committee for study and report to the Semiannual meeting of the Faculty. This dealt with the Title 19 program and individual physician "participation" in the program.
12. Distributed the Report of the Ad Hoc Committee to Revise the Medical Practice Act, which will be discussed at the Semiannual session.
13. Rejected a motion to conduct another management study of the Faculty's operations.
14. Referred to the Bylaws Committee, a proposal that Council membership be flexible and based on a formula as is the House of Delegates membership.

The Council of the Medical and Chirurgical Faculty met on the dates shown and took the actions shown;

Wednesday, April 17, 1968:

1. Approved recommendation for Emeritus Membership to the Faculty's House of Delegates for J. Douglass Shepperd, MD, Baltimore.
2. Ratified Physician's Defense for two physicians requesting it.
3. Authorized introduction of Resolution 6A/68 into the House of Delegates for consideration of the House. (*See House of Delegates summary, April 19, 1968*).

Friday, April 19, 1968:

1. Elected John F. Schaefer, MD, Baltimore, as Council Chairman.
2. Elected Manning W. Alden, MD, Annapolis, as Council Vice-chairman.

At a General Meeting of the Faculty Membership, held on Thursday, April 18, 1967, at the Alcazar, the following members were elected to the terms shown on the Board of Medical

Examiners:

For four-year terms commencing June 1, 1968: Karl F. Mech, MD, Baltimore; and Archie R. Cohen, MD, Hagerstown. For a three-year term, commencing June 1, 1968, Gerald A. Galvin, MD, Baltimore; and for a one-year term commencing June 1, 1968, John J. Curry, MD, Silver Spring.

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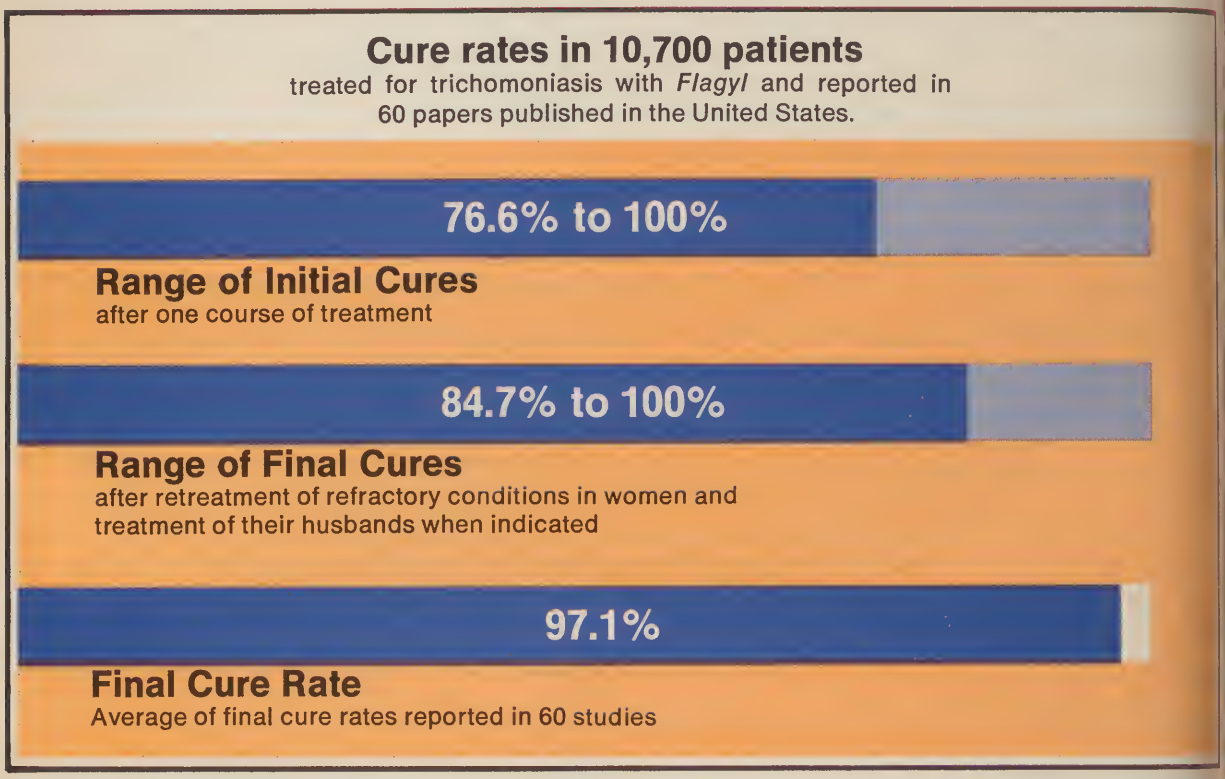
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n clinical practice an occasional uncooperative or drug-sensitive patient r spouse makes 100 per cent cure of trichomonal vaginitis in large series f patients difficult.

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Analysis of all of these papers shows that the incidence of cures for ne *initial* course of therapy ranged from 76.6 per cent to 100 per cent. 'he cure rates after retreatment of female patients and treatment of their usbands when indicated ranged from 84.7 to 100 per cent. The average nal cure rate reported in all investigations was 97.1 per cent.

ominal cramping, constipation, stomatitis, umbness or paresthesia of an extremity, joint ains, confusion, irritability, weakness, cystitis, elvic pressure, dyspareunia, fever, polyuria, inontinence, decreased libido, nasal congestion, roctitis and pyuria. Elimination of trichomonads ay aggravate candidiasis.

Dosage and Administration: In women: one 50-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local herapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.

In men: When trichomonads are demonstrated, one 250-mg. oral tablet twice daily for ten days in conjunction with treatment of his female partner.

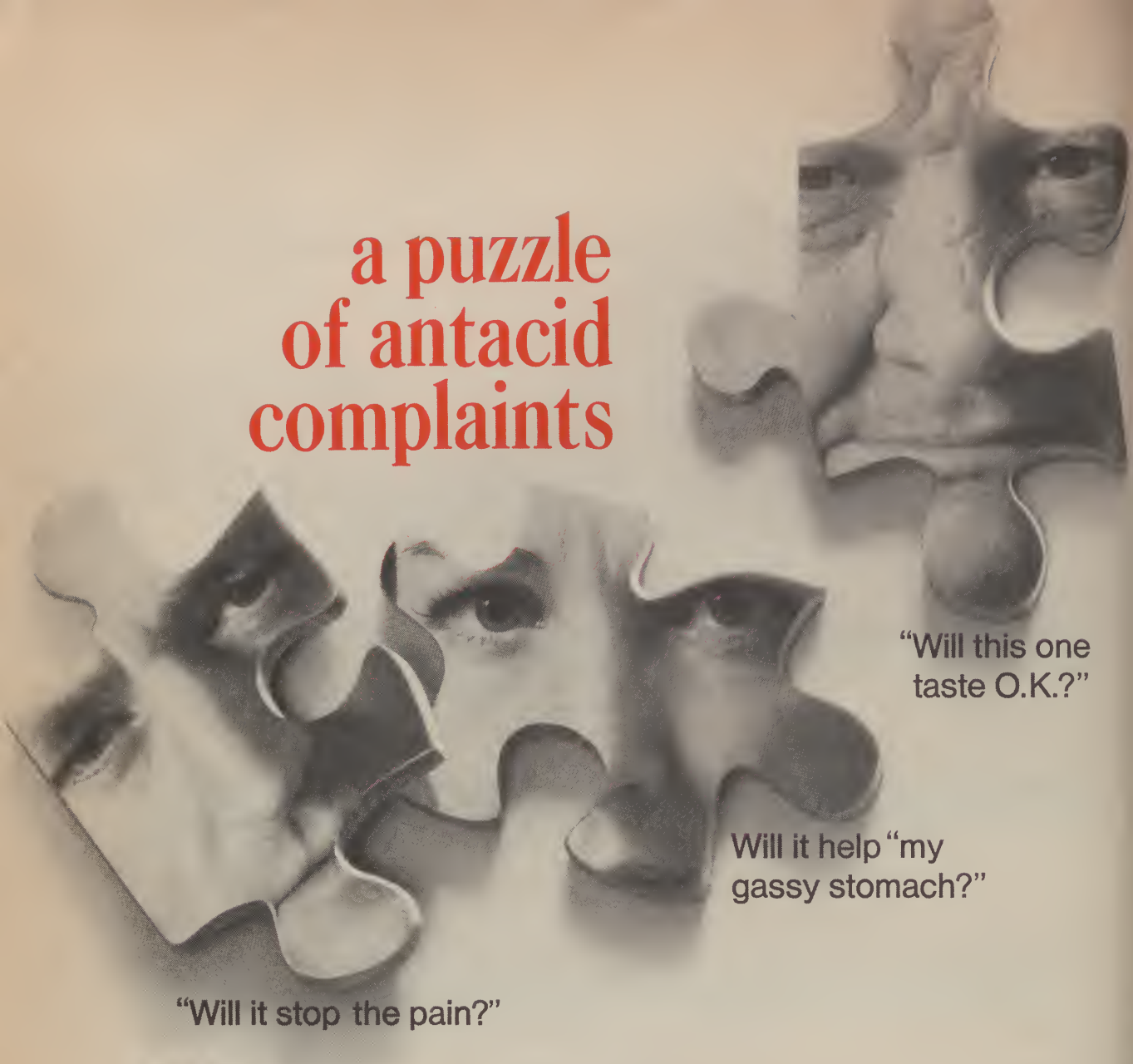
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1. Complete list of references on request.

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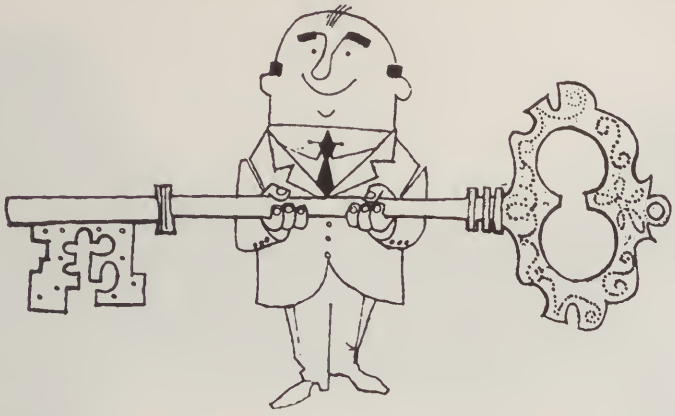
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References: 1. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966.
2. Danhof, I. E., Personal communication.

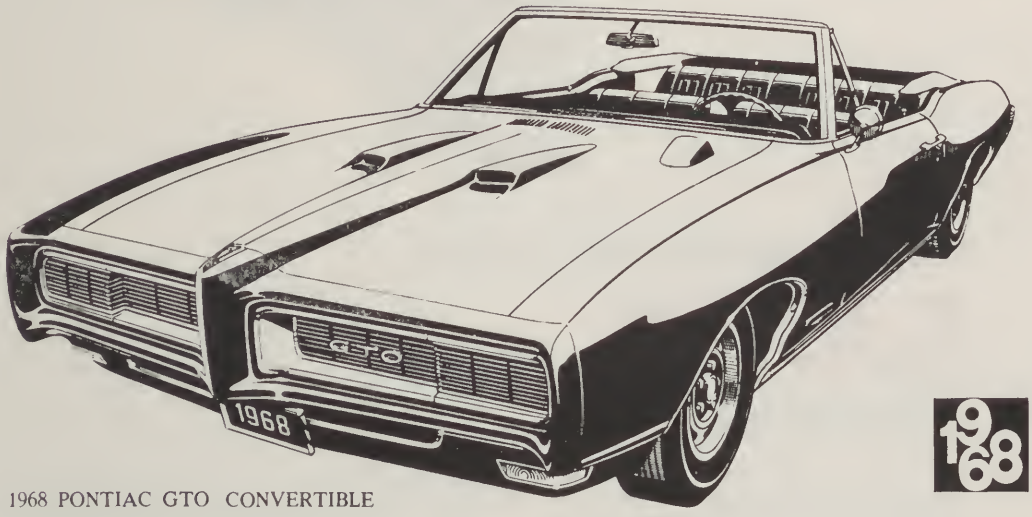
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Medical News

Samuel P. Asper, MD, of Baltimore, has been named President-elect of the American College of Physicians. The election took place during the business meeting of the college's 49th Annual Session in Boston in April.

Dr. Asper, professor of medicine at The Johns Hopkins University School of Medicine, will become President of the 14,000-member specialty society at its 50th Annual Session in Chicago next April.

Another Baltimore internist, **R. Carmichael Tilghman, MD,** has been elected Secretary-General of ACP. In his new capacity, he will serve as ACP's corporate secretary and as Chairman of the Committee on Credentials. Dr. Tilghman is an associate professor of medicine at The Johns Hopkins University School of Medicine.

* * *

The Joseph P. Kennedy, Jr. Foundation has selected as its recipient of the International Leadership Award, **Robert E. Cooke, MD,** of Baltimore. The award was presented to Dr. Cooke during the latter part of April in Chicago by Sargent Shriver, the foundation's executive director.

Dr. Cooke, Given Foundation Professor of Pediatrics and director of the department of pediatrics at The Johns Hopkins University School of Medicine, was nominated by Thomas B. Turner, MD, dean of the school of medicine in recognition of his acts of leadership in the field of mental retardation which span 16 years.

* * *

Merwyn Bagan, MD, a resident of The Johns Hopkins Hospital, received a third place prize in the 10th Annual Competition for the SAMA–Eaton Medical Art Awards. His winning entry, "Hemangioma of the Eyelid", won in the photography category of the Medical Student/House Staff Division of the contest.

* * *

Robert Derbyshire, MD, associate professor of sociology in psychiatry at the University of Maryland School of Medicine, was honored as Faculty Member of the Year by the school's student council at its annual banquet in May.

A member of the Maryland faculty since 1961, Dr. Derbyshire teaches freshman psychiatry and is director of undergraduate psychiatric education. Also, he is coordinator of a summer fellowship program in psychiatry at the medical school, and teaches at University College and the Schools of Nursing and Social Work.

* * *

Recipient of the 1967 Award of the Enuresis Foundation was **Barbara Starfield, MD,** of The Johns Hopkins Hospital.

The fourth annual award was presented to Dr. Starfield for her significant contribution to the knowledge and understanding of enuresis and its related afflictions. Dr. Starfield was cited for the award after publication of her paper, "Functional Bladder Capacity in Enuretic and Non-enuretic Children" which appeared in the Journal of Pediatrics in May of last year.

* * *

The Johns Hopkins Department of Biology and the McCollum-Pratt Institute have been awarded $77,343 by NIH to improve laboratory animal facilities, equipment and management. This will result in expanded research potential in biochemistry, genetics and immunology.

* * *

A three-year project to find means of making corneal graft surgery possible in cases now generally considered inoperable is being supported at **The Johns Hopkins University School of Medicine** by a $269,507 grant from The John A. Hartford Foundation, Inc., of New York City.

The project, also designed to develop improved surgical and eye bank techniques, is under the direction of **David Paton, MD,** and **Miguel**

Martinez, MD, faculty members of the school and ophthalmologists at The Wilmer Institute.

* * *

Lloyd Grenfell Stevenson, MD, of Yale University, will become the director of the Institute of the History of Medicine at The Johns Hopkins University School of Medicine on July 1 of this year.

Dr. Stevenson, presently professor and chairman of the department of history of science and medicine at Yale, will succeed Oswei Temkin, MD, who has been a member of the Hopkins faculty since 1932. Dr. Temkin will continue to teach and will devote much of his time to research.

* * *

The appointment of **David D. Swenson, MD,** as Chief of the National Clearinghouse for Mental Health Information, Office of Communications, has been announced by Stanley F. Yolles, MD, Director, National Institute of Mental Health.

A psychiatrist, Dr. Swenson has been acting Managing Director of the Clearinghouse since August of last year. As the scientific and technical information resource center of the Institute, the Clearinghouse is responsible for the collection, storage, retrieval, and dissemination of information from scientific and professional literature, mental health programs, and other pertinent sources.

* * *

Charles L. Schultze, former Director of the Bureau of the Budget of HEW, has been appointed Chairman of the Health Insurance Benefits Advisory Council. Mr. Schultze is now professor of economics at the University of Maryland and senior fellow with the Brookings Institute.

* * *

One of the new members of the Health Insurance Benefits Advisory Council is **Russell A. Nelson, MD,** President, The Johns Hopkins Hospital and Past President of the American Hospital Association.

* * *

Alejandro Rodriguez, MD, associate professor of pediatrics and psychiatry at The Johns Hopkins University School of Medicine, has been made director of the division of child psychiatry at the school.

Dr. Rodriguez took his residency training in both pediatrics and psychiatry at Johns Hopkins. He served his internship in pediatrics at Stanford University.

* * *

A major contribution has been received by The Johns Hopkins University School of Medicine toward the establishment of a permanently endowed chair in medicine in honor of one of the school's most distinguished graduates, **Stanhope Bayne-Jones, MD.**

The contribution, from an anonymous donor, later will be combined with additional contributions to support the Stanhope Bayne-Jones Professorship of Medicine. Dr. Bayne-Jones is a distinguished bacteriologist and medical educator now living in Washington, D.C.

Thomas B. Turner, MD, dean of the School of Medicine, said that pending activation of the Professorship, income from the new fund will be used to support the Stanhope Bayne-Jones Lectureship which will be oriented to problems in infectious diseases, microbiology, epidemiology and preventive medicine. The first lecture is scheduled to be presented in the fall, during the school's 75th anniversary year.

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A House Divided Against Itself . . .

WILLIAM J. PEEPLES, MD, MPH
Commissioner of the Maryland State Department of Health

During the months of the last General Assembly, Baltimore's rival evening newspapers made sensational headlines with the Medical Assistance Program. "Revelations," "probes," and "senatorial investigations" were frequent predictions, colored with such words as "confessed," "denied," "revealed," "accused," etc. For example, a December 22, 1967 column began (*italics ours*):

"The Maryland Department of Health *admitted* today it *still must* rely on a doctor's 'basic honesty' (*quotation marks theirs*) that he has treated the patients *claimed* under the State Medical Assistance Program."

The actual statement was: "The Maryland Department of Health said today it has always relied on a physician's honesty in billing the State for treatment of patients under the Medical Assistance Program, and has found no reason to alter this policy." True, but not controversial; therefore not "good" newspaper copy.

Observe what the reporter's opening statement does: It suggests that some (maybe all?) physicians are either dishonest or greedy, and further that the Health Department is and has been either naive or stupid to believe otherwise. Both groups are guilty by implication, and put on the defensive. But this is not enough.

The statement undermines the reader's confidence in his physician, and in his state agency's handling of his tax funds. It casts doubt on the merits of a pioneer program of care for the needy which has commanded widespread admiration and respect throughout the Nation for many years. It sows seeds of ill feeling and distrust among those whose cooperation is essential to the success of the program. It pressures legislators to probe, to investigate, and to look warily at the proposed budget for the program.

Earlier, of course, the Health Department had been scored for its refusal to give reporters access to records involving payments to physicians, "despite the fact," complained the press, "that the Medical Assistance Program is completely publicly funded." And, of course, despite the Attorney-General's opinion that the records were confidential.

The Legislature's right of access to the records of disbursement of public funds was never in question, and their representatives were supplied with all possible statistics and information needed for their proper interpretation. Obtaining these figures from the legislators, reporters skimmed "the cream" off the top and published the names of the ten physicians who had received the greatest sums for their care of Medical Assistance patients. They failed to point out that the payment totals represented gross rather than net income. Only the morning paper included the number of patients each had treated, the number of visits the payments represented, and the average cost to the State per patient for the year covered.

The wounds were kept festering by similar distortions of the truth, e.g.: "The two groups have been at each other's throats over the besieged medical assistance program . . . and a spokesman for the doctors indicated today that the department was to blame . . . Dr. Peeples laid down a barrage of possible explanations . . ."

A recent editorial stated, "Fundamentally the rights of the press are the public's right to know." No one, in our democratic society, questions the public's right to know how its tax funds are being expended. That is the crux. The public has the right to know the *complete* story, not an irresponsible conclusion drawn from the distortion or

omission of facts needed for full understanding. Ignoring pertinent facts points less to a desire to inform and more to arouse controversy. In this the press reminds one of Wimpy, the hamburger-cadging character in the Popeye cartoon strip, with his frequent exhortation, "Let's you and him fight," while he stood by to cash in on the proceeds.

The tragedy of truth manipulation is not so much its effect on the groups "set at each other's throats," but the damage it inflicts on the sick and poor for whose benefit Maryland's medical care programs were designed.

This was the theme of a prominent physician's vigorous reply to the editors of the *Evening Sun.* After castigating earlier story treatment of the Medical Assistance Program, he continued: ". . . your latest article . . . is not only inaccurate but is an example of distorted and prejudicial writing that will only confuse the average reader and cause further problems . . . In your anxiety to make the State Health Department and the physicians of Maryland look like scoundrels, you have inaccurately criticized a program which for many years has served as a model for other states seeking a progressive and well-run health program for the indigent. I think you owe the Health Department and the physicians of Maryland a public apology." None was forthcoming.

A professor at Johns Hopkins Medical School and one of the framers of the original Home and Office Medical Care Program, said more than a year ago in an informal address to the Medical Assistance Advisory Committee, "Officials of the State Health Department here can attest to the fact that again and again inadequate amounts were appropriated for supporting the program which they [the legislators] had enacted for Medical Care . . . Every time more money was needed, somebody would suggest a review, supposing that somebody was just putting the money into his pocket. And it would turn out as it probably still does, that one doctor would be seeing far too many patients; many more than he could probably care for adequately, but we have to say that he was willing to try."

It is almost 30 years since the Medical and Chirurgical Faculty requested the State Planning Commission to form a Committee on Medical Care to study the problems of providing for the needs of the indigent and medically indigent. Turning first to the counties, where the needs were most pressing, this committee made an intensive and thorough survey of the situation, and in its 1944 report commented on the then current practice of physicians contributing time and services to clinics, "We have not found a single instance in which a part-time physician has been able to render a significant amount of medical care for the indigent and at the same time earn a livelihood in the private practice of medicine."

The confusion, variety, inadequacy and delays in methods of payment for medical care and drugs for "relief" clients were cited, as were the disinclination of hospitals to take free or part-pay patients, the reluctance of young physicians to settle in economically depressed areas, the growing complexity and expense of modern medical practice, the paucity of Negro physicians, and the low health status of the economically deprived population.

Among many significant statements contained in the report were these: "In many areas . . . medical services are, in general, restricted to bare emergency services, and these deficiencies constitute a serious and urgent problem, particularly when it is clear that the lack of medical care and rehabilitation is frequently the basic cause of indigency . . ."

"The community has become so accustomed to accepting the medical profession's disproportionate burden in the medical care of the indigent, that there is danger that it may assume, without justification, that these free services will always be available in sufficient amount to meet the needs. Changing conditions, however, make it doubtful whether such an assumption is justified."

And from a physician interviewed, "I've never turned down a patient in my life . . . but believe me, I've done a hell of a lot of grumbling."

The outcome of the Committee's report was the establishment of the Home and Office Medical Care Program in the counties, and later in Baltimore City, under the administration of the State Health Department, and the establishment by statute of the Council on Medical Care. The physician distribution problem was partially recognized by travel allowances for home visits as well as clinic and consultant services. Fee allowances were not too disparate then from usual charges, but increases in this aspect of the program have lagged behind others—notably the inpatient, nursing home, and pharmacy programs.

Efforts have continued from year to year to

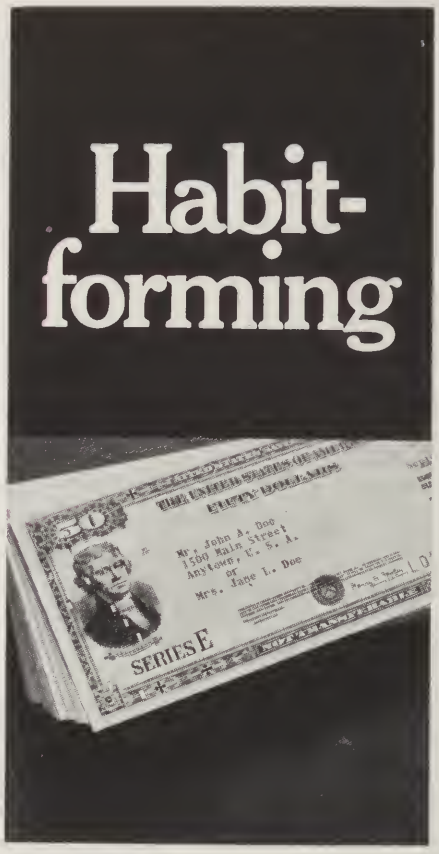
achieve appropriations from the Legislature which would permit realization of the aims of improving the delivery of services, of providing routine as well as emergency care for the indigent and medically indigent, of solving shortages of medical and paramedical manpower—in short, of providing all citizens of Maryland, whatever their place of residence or economic status, the opportunity to achieve their greatest health potential.

The passage of the Medical Assistance legislation in 1965, increasing Federal participation in programs of care for the needy, seemed to offer a means of furthering these objectives. The reality, however, has been beset with complexities, partly due to delays and rigidities in the Federal program, partly to the lack of adequate staff to handle the increase in the State program, but also to the State's failure to appropriate sufficient funds to implement the plan, especially in view of rapidly rising costs of medical care.

One of the most powerful bulwarks created to bolster the availability of services has been the medical care program. It is essential that it be continued and constantly improved, rather than restricted, if the desired goals are to be achieved. One Eastern Shore physician, who has practiced for years in a rural area of great need, has written:

"We cannot get [physician] replacements in depressed or rural areas . . . I have felt it is a privilege as well as a bounden duty to serve as I have served. It also has been a pleasure and joy that has made my life more than full. The Medical Assistance Program has been one of the inducements to attract people [physicians] to these areas, but with the reasons mentioned in this letter, I for one would be very hesitant to recommend anyone to come to areas such as mine. Unjustified harassments, quotations out of context, distortion of facts and figures, and lastly but not leastly the possibility of galloping inflation are making positions such as mine more and more unattractive."

Our problems are many, and have no easy answers, but the hue and cry of the press militates against careful and far-sighted consideration of the needs and their solutions. Certainly, if the needs are to be met, it is essential that the medical profession and the health agencies not allow themselves to be badgered into actions which will jeopardize our historic progress in the field of health for Maryland's citizens, but rather present a united front in a combined effort to achieve their common aim.



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HEART PAGE

Chris Papadopoulos, MD, Editor

A Service of the Heart Association of Maryland

Progress in Pediatric Cardiology

Pediatric cardiologists have climbed so far and so fast on the hills of knowledge since the blue baby era opened in the forties, that they now a little breathlessly suspect they are on a plateau. Presented here are only highlights of the past ten years, omitting cardiac transplants and their possible role.

CATHERINE A. NEILL, MD, MRCP
Associate Professor of Pediatrics,
Cardiologist, Cardiac Clinic
Children's Medical & Surgical Center
The Johns Hopkins Hospital

Infants

Emphasis has shifted from the child with heart disease to the infant. The major mortality and morbidity is in the first year of life and this remains true despite all endeavors. The greatest single advance in the infant age group in the last few years has been the Rashkind procedure for transposition of the great arteries. By ingenious use of a balloon catheter, the atrial septum is ruptured, allowing the mixing of blood between the two circulations essential for continued survival. Thus, when successful, the infant has undergone surgery without a thoracotomy and the cardiac catheterization, usually only a diagnostic procedure, has also been therapeutic. The development of this procedure has made even more imperative the early referral, admission and treatment of all sick cyanotic newborns, if further significant improvement in salvage rates is to be achieved. An infant with transposition of the great arteries in whom an atrial septal defect is created, now has a far brighter future than before, for around three or four years of age a Mustard operation may be possible completely eliminating cyanosis and restoring the child to normal activity.

Children

Progress has been mainly in refinement and improvement of clinical diagnosis, catheterization techniques and surgical skills. Thus, in at least 75 to 80% of cases, it is possible to make a correct clinical diagnosis prior to catheterization. For a number of reasons, the great majority of cardiac patients still undergo catheterization tests but in a few years, one hopes this will no longer be true and that the technique will be reserved for real diagnostic problems and for physiological research in abnormal myocardial function. The advent of cine-catheterization has had its primary use in clinico-physiological correlation. For example, in watching the domed thickened valve of aortic stenosis move on the screen, one understands far better the ejection click and the murmur audible with the stethoscope. Cine-catheterization has also proved particularly useful in complicated cases with more than one intracardiac defect, and in generalized arterial problems as the rubella syndrome.

Surgery has progressed chiefly in improvements in cardiopulmonary bypass management, so smaller and sicker patients are now operable, and in the use of the respirator and other methods of postoperative support. The development of prosthetic valves and homografts has rendered operable some children who could not be treated a few years ago. Thus, the majority of children undergoing open heart surgery are active and of good color within 24 hours of surgery. Because of these improvements the tendency now is to undertake surgery

in most children with operable defects between four and six years of age so that they can have normal activity when they start school.

Adolescents and Adults

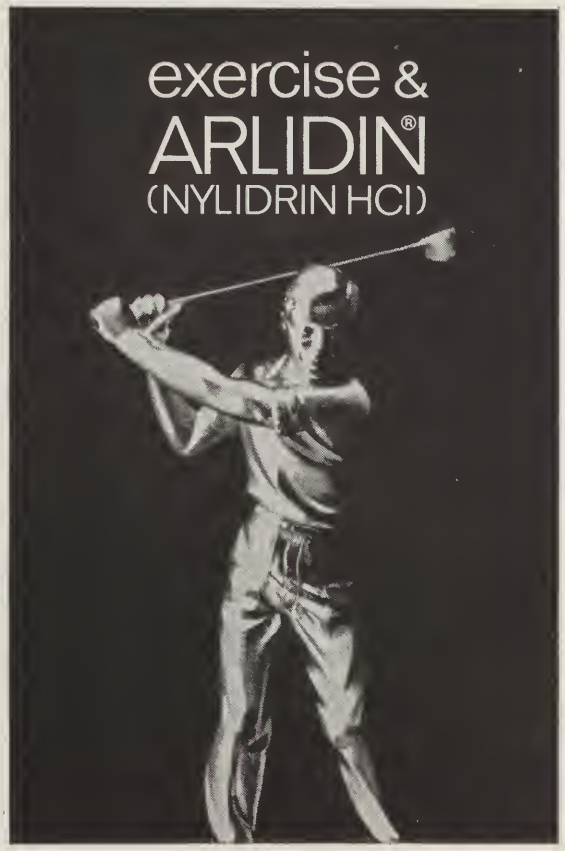
Several centers including our own have set up special clinics for the adolescent with heart disease. They are beginning to explore the best ways of working with the school and college in finding the best occupations for those in whom complete correction has not been possible. Virtually a sub-subspecialty has developed in the management of pregnancy in patients with congenital heart disease, which poses quite different problems from the rheumatic group.

Future Progress

Pediatric cardiology, like many other subjects, is now having to move into new areas. As more cardiac centers have opened, the need for each to consider first its own geographical region and its needs, has become apparent. This will involve changes in admission procedures, clinic staffing and new collaborative efforts between cardiac centers and regional pediatricians, school officials and others. Increasing attention to the signs of heart disease in the newborn and intense effort to salvage the seriously affected infant will be accompanied by increasing and more skillful efforts to keep healthy and active those with functional murmurs or only trivial cardiac defects and those whose hearts are now normal following surgery. The research approaches to etiology and prevention have been scanty indeed and these are being expanded.

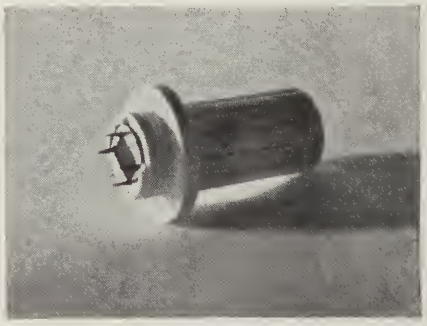
Pediatric cardiologists are also becoming concerned with their role in the early detection of hypertension and the prevention of dietary and activity patterns which might predispose to arteriosclerosis.

One would predict then, that progress in the next ten years will be chiefly in diagnosis and management of infants, in cooperative regional arrangements with public health and epidemiologic teams, and in the broadening of the concept of pediatric cardiology beyond the congenital malformation field. Perhaps ten years from now, one of our group will write a follow-up on how true or untrue this prediction proved to be!



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ALCOHOLISM SECTION

One Man's View of Alcoholism and the Alcoholic

The Baltimore Area Council on Alcoholism has provided a vigorous leadership role in developing interest and concern about alcoholism for many years now. It is a citizens' group which has been in a strategic position to maintain both a stimulating and critical role so essential in developing concerned, sustained effort and creative approaches to important issues. The support of this organization played a very important role in the passage of Senate Bill No. 389 which has been enacted into law through the Governor's signature and which will become effective July 1, 1968.

ISADORE TUERK, MD
Commissioner of Mental Hygiene

This bill marks a salient advance in public acknowledgement of the existence of alcoholism as an illness: It provides for the treatment of individuals suffering from public intoxication rather than their incarceration as criminals; it provides for the development of a variety of important facilities in the State for the treatment and prevention of alcoholism and the rehabilitation of alcoholics; it establishes a Division of Alcoholism Control in the Department of Mental Hygiene with a great variety of important functions; it provides for limited involuntary treatment of alcoholics under appropriate circumstances, but emphasizes the desirability of voluntary treatment; hopefully, it will take the pressure off the State mental hospitals and will result in the establishment of many community-based programs and facilities.

Despite the recommendations of the American Hospital Association and the American Medical Association, general hospitals have been extremely slow in being receptive to the admission and treatment of patients with acute alcoholism. Some little progress has been witnessed in Maryland, but much still needs to be done.

Steps have been taken to involve industry in the treatment of the alcoholic. Here, also, industry, using constructive coercion and enlightened self-interest, can preserve employed manpower by making available treatment resources early. Halfway houses, clinics, acute detoxification centers, long-term treatment programs and facilities are all urgently needed in Maryland.

It is regrettable that additional funds were not made available to implement Senate Bill No. 389, but I am convinced that such funds will be forthcoming and that in the meantime Baltimore City and other local communities along with the State can use current resources more effectively and appropriately.

Designating alcoholism as an illness has very definite implications, not only in legal terms but also in therapeutic terms. As you well know, this is a concept that is not entirely acceptable in many professional circles. There are those physicians and psychiatrists who see alcoholism as a symptom of some other underlying disorder; there are those who regard alcoholism in archaic terms of immoral, weak personality characteristics, worthy only of condemnation. There are those who look upon it as simply a manifestation of ethnic and sociological difficulties. Despite strenuous research efforts, so far no authentic or validated cause either in the biochemistry of the individual or in his personality structure or early life experience can be established.

Designating alcoholism as an illness is medically and socially sound, in terms of a legal approach to the problem, but also more significantly, in terms of the challenge this then poses to the medical profession and to scientists in general to examine

Presented at the Annual Meeting of the Baltimore Area Council on Alcoholism, April 25, 1968.

this important public health problem and to discover more than we now know about the causes, the prevention and the treatment.

Despite the efforts of Alcoholics Anonymous, physicians, ministers, psychologists and sociologists, alcoholism continues to be rampant in our country and in our State. Treatment efforts, although gaining in applicability, still encounter limited success. Problems of overcoming poor motivation for treatment still confront us and problems in dealing with the motivated alcoholic in achieving and maintaining sobriety are still burning issues!

Antabuse has its value—
Individual psychotherapy has its value—
Group therapy has its value—
Family therapy has its value—
Alcoholics Anonymous has its value—

But despite all of these approaches, there continue to be too many failures, and too few individuals suffering from alcoholism are actually involved in treatment.

The philosophy of Alcoholics Anonymous to utilize their program and not to analyze is confronted by the philosophy of many psychiatrists that in order to utilize it is necessary to analyze. Probably there is truth in both approaches.

The extremely interesting phenomenon which is apparent to everyone who works with alcoholics is that individuals reach the state of alcoholism in many ways: Some drink in a problem manner from the very first drink they have; others apparently drink socially for a long period before they cross over into the area of alcoholism with its uncontrolled and serious problems; others do not become alcoholics until they are exposed to a serious crisis in their lives; still others clearly have an associated illness such as schizophrenia or chronic organic brain syndrome.

Perhaps the key denominator in all of these is that individuals may have vulnerability toward the development of alcoholism which may be either excessive or minimal and the degree of stress required to bring out this disease will vary.

In my experience, however, once the individual has incurred the symptoms and manifestations of alcoholism, regardless of the route, he then suffers from a specific entity which requires its own understanding and its own treatment. So far, an axiom in the treatment of the alcoholic is that there is no way except total and lifelong abstinence. Perhaps this is an axiom based upon our limited knowledge, and perhaps it needs to be carefully researched under strict scientific conditions. I certainly know many alcoholics who have researched it in their personal lives only to discover over and over again to their chagrin and dismay that they cannot regain the capacity to drink in a controlled, personally acceptable or socially acceptable manner.

The treatment of alcoholism requires a great many individuals and a great variety of individuals including recovered members of Alcoholics Anonymous, alcoholism counselors, ministers, physicians, psychiatrists, psychologists, social workers, etc. The main quality that these individuals need is a sympathetic understanding of the problems of alcoholism as a disease entity, its possible relationship to other conditions, and, most importantly, a sensitivity to the personality structure of the alcoholic and their own personality so that the interaction between them and the alcoholic is a constructive, curative one, rather than a destructive, punitive one.

It is necessary that there be a continuing effort to sharpen our self-understanding and the understanding of our alcoholic patients in order to deal appropriately and wisely with them. Alcoholics Anonymous has wisely learned that those who go out on twelfth-step work need to be reasonably mature and reasonably secure in dealing with the demands of that kind of situation not only in being helpful to the alcoholic but also in preserving the twelfth-stepper's sobriety. Counselors and psychiatrists, et al, need to be alert to the skillful, ingenious and varied manifestations of the maneuvers of the alcoholic in rationalizing his drinking and in persisting in a course of continued drinking or recurring drinking. If this is approached with understanding and with the ongoing need to learn from experience, both patient and therapist will profit by the rewards in sustained and productive sobriety. The therapist needs to be able to face failure with equanimity and without resentment . . . often, there are unexpected good results, but every such unexpected good result should be analyzed to determine what occurred to make it possible.

In other words, sustained sobriety is an invaluable life-preserving and life-fulfilling accomplishment for the alcoholic, and to work with the alcoholic is a fascinating adventure in unraveling the many noxious forces of the human being that stand in the way of his happiness and fulfillment.

TUBERCULOSIS SECTION

A Service of the Maryland Tuberculosis Association

Chemoprophylaxis for the Prevention of Tuberculosis

A Report of the Ad Hoc Committee on Chemoprophylaxis

Since the publication in February, 1965, of the statement by the American Thoracic Society Committee on Therapy entitled "Preventive Treatment in Tuberculosis," the indications for chemoprophylaxis have widened. The National Tuberculosis Association Committee for the Guidance of the Tuberculosis Program established an Ad Hoc Committee on Chemoprophylaxis with representation from the ATS Committee on Therapy, the ATS Committee on Respiratory Diseases in Children, the United States Public Health Service, and the NTA Committee for the Guidance of the Tuberculosis Program, which prepared the following statement:

■ *Antimicrobial drugs,* which have revolutionized the therapy of tuberculosis, can also be effectively used in chemoprophylaxis, the prevention of disease in the infected individual. Chemoprophylaxis presumably acts by diminishing the bacterial population in "healed" or invisible lesions of the person taking the drug. It is in reality treatment of infection and prevents clinical disease from developing or relapsing.

A substantial and growing body of scientific data testifies to the value of anti-tuberculosis drugs in prevention of clinical tuberculosis. The extensive trials conducted by the United States Public Health Service show a consistent reduction of morbidity in treated groups; it seems reasonable to expect that chemoprophylaxis can reduce future morbidity from tuberculosis in high risk groups by some 50 to 75%. The extensive use of chemoprophylaxis now would likely reduce by 300,000 the total number of cases in the United States in the next 15 years.

Reprinted from *The American Review of Respiratory Disease,* Volume 96, Number 3, September 1967.

Drugs Used in Chemoprophylaxis

A single drug, isoniazid, is generally used for chemoprophylaxis in a dosage of 300 mg per day for adults and 10 mg per kg body weight per day for children, not to exceed 300 mg per day, to be administered in a single daily dose for a period of 12 months.

There are virtually no side effects. The toxicity to this drug is low, apparent in only 0.2 to 0.4% of those taking the drug, and it is easily reversible. Follow-up studies for periods of up to fifteen years of groups of people who have been treated with isoniazid have revealed no evidence of long-term deleterious effects from its use. Isoniazid is also inexpensive.

Persons Recommended for Chemoprophylaxis

Every positive reactor is at some risk of developing active disease. Thus, any person found to have a reaction of 10 mm or more to the Mantoux test, using 5 TU of PPD, should receive chemoprophylaxis whenever he is identified.

Since in the immediate future it is not practical to test and treat the entire population of positive reactors, priorities must be set for public health programs taking into consideration the relative risk of developing active disease, the opportunities of infecting others, particularly children, and the resources available in the community. The total cost must also be taken into account.

For certain groups, chemoprophylaxis is mandatory. These groups include certain inactive cases, certain special clinical situations, contacts, tuberculin converters and positive reactors among young children and adolescents.

Inactive Tuberculosis. First priority for chemoprophylaxis should be given to persons with inactive tuberculosis. These include:

1. Ex-patients; persons who have had active tuberculosis and had no drug therapy or had inadequate drug therapy.
2. Persons with roentgenographic findings consistent with healed adult-type pulmonary tuberculosis and a positive tuberculin test. (Some persons over age 55 may react negatively to 5 TU of PPD, and a larger dose of tuberculin may be necessary to elicit a reaction.)

Note: It is essential to exclude active disease in these groups by bacteriologic examinations, comparison with previous radiologic findings, and other investigations because people with active disease require more intensive drug treatment.

The rate of reactivation among these inactive cases is between 0.5% and 2.0% a year. Many of these cases are known to health departments. It is a worthwhile program to review the records of inactive cases, and recall them for assessment of the need for chemoprophylaxis. Such a program directed towards a well-delineated group would be more practical than surveying the whole community.

Special Clinical Situations. A person with a positive tuberculin test is in danger of activation or reactivation of tuberculosis in certain clinical situations. Such a person should receive chemoprophylaxis whether or not he has been treated with isoniazid before:

1. If he is placed on corticosteroid treatment;
2. If he undergoes gastrectomy;
3. If he has reticuloendothelial disease such as leukemia or Hodgkin's disease; or
4. If he has a period of instability of severe diabetes.

In the case of a pregnant woman who has inactive tuberculosis previously untreated with chemotherapy, or who has roentgenographic shadows consistent with inactive tuberculosis, chemoprophylaxis should be started in the last trimester and continued for a year.

When measles or whooping cough develop in children with a positive tuberculin reaction they should receive eight weeks of chemoprophylaxis if they have been treated before; the course of chemoprophylaxis should be extended to 12 months if they have not received previous treatment.

Contacts. Contacts of recently discovered new active and reactivated cases of tuberculosis show a high incidence of this disease. Contacts should be examined and those diagnosed among the contacts as having tuberculosis should be reported and treated.

All household contacts of a reported active case of tuberculosis should receive chemoprophylaxis for twelve months if their reaction to the Mantoux test with 5 TU of PPD is 5 mm or more of induration. In such instances, a 5 mm reaction is most likely the result of exposure to tuberculosis and not a cross reaction due to infection with atypical mycobacteria. Those household contacts who show negative Mantoux tests should be retested every three months until at least three months have elapsed since the last exposure. If the skin test converts, chemoprophylaxis should be instituted.

An alternative approach is to give chemoprophylaxis to all household contacts, including those with negative tuberculin tests. Positive reactors remain on the drug for the full course. Negative reactors should be retested three months after last contact with the active case. If the contact has been assuredly broken and if they are still negative to tuberculin, chemoprophylaxis may be discontinued. When exposure may be continuous it it desirable to give chemoprophylaxis to tuberculin negative contacts for as long as exposure continues. This may also be advisable in epidemics in closed groups and in situations in which it is impossible to retest the negative reactors at regular intervals.

Other Positive Reactors. In addition to the positive reactors just described, chemoprophylaxis should be given to the following reactors with normal chest films:

1. Converters: Known converters of all ages should receive chemoprophylaxis.
2. Certain positive reactors under age 20: Chemoprophylaxis is mandatory for positive reactors through the age of school entrance and for teenagers because of the relatively high risk attending tuberculous infection in these age groups.

Instituting the Chemoprophylaxis Program

Chemoprophylaxis can be instituted on a widespread basis through two major means.

1. The family physician, pediatrician or internist can institute chemoprophylaxis on an individual basis in patients who have a high risk of developing active tuberculosis.
2. Community agencies can work with the high risk groups that can be approached through a public health program. In many instances, these persons are already known to health departments and their names are in the files of closed cases and in the reports from screening programs.

Motivation of Patient

With adequate motivation, most patients will accept and stay on drugs for the full course. Enthusiasm and encouragement by the physician, nurse, and other health personnel involved are key factors. At the beginning of a course of prophylaxis, the physician should take time with the patient to establish understanding and motivation. Subsequently there should be regular visits with the public health nurse, either in the clinic or at home, to reinforce the physician's teaching. Patients should be helped to develop their own systems of reminders to take drugs daily. In addition, maintaining the drug schedule should be made easier for patients by removing obstacles such as difficulties in getting to clinics for follow-up visits or in obtaining drug refills.

Prepared by the Ad Hoc Committee on Chemoprophylaxis

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Alfonso H. Holguin, MD (U.S. Public Health Service)
Captain Donald C. Kent, MC USN (ATS Committee on Therapy)
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J. A. Peter Turner, MD (ATS Committee on Respiratory Diseases in Children)
Edward J. Welch, MD (NTA Committee for the Guidance of the Tuberculosis Program)

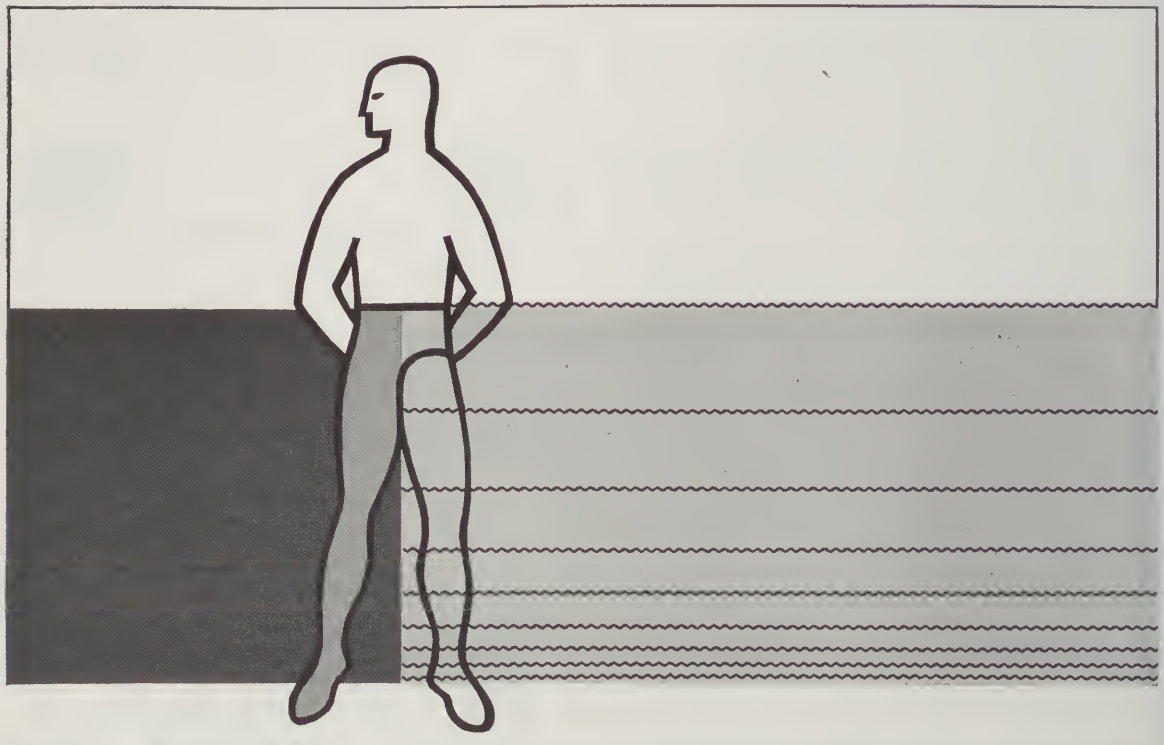
Approved May 21, 1967, by the NTA Committee for the Guidance of the Tuberculosis Program and the American Thoracic Society Executive Committee. Accepted by the NTA Board of Directors on May 27, 1967.

JANUARY	FEBRUARY	MARCH	APRIL
	5%		
MAY	JUNE	JULY	AUGUST
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FEBRUARY, May, August and November—they're the months that Security Savings & Loan (a stock corporation) pays dividends . . . compounded daily . . . at the current rate of 5% per annum. Savings earn dividends at this unusually high rate from the day you put them in until the day you take them out. Open your account now. For security, flexibility, and 5% per annum paid on daily balances, save with Security 24 E. Fayette Street.

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The Jobst® Venous Pressure Gradient® Support

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Each is custom fitted and tailored to your prescription for your individual patient to provide the best therapy for his or her particular case. Six different types are available to produce return flow in veins and tissues of the extremities, add to patient comfort and well-being, help restore health to the extremity.

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A simplified approach to the practical management of hypertension



Enduron: (methyclothiazide) A basic building block for mild hypertensives



Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persists for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

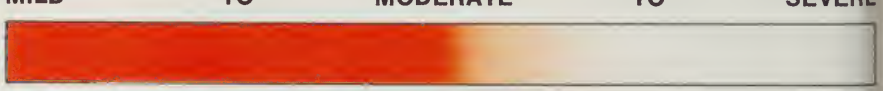
Of course, as with all thiazides, supplemental dietary potassium should also be considered.

Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

ENDURON®

METHYCLOTHIAZIDE



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

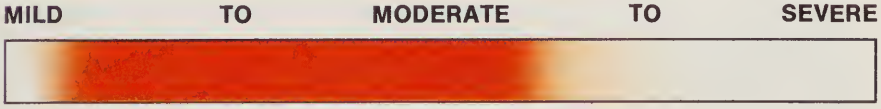
Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

Once a day, every day

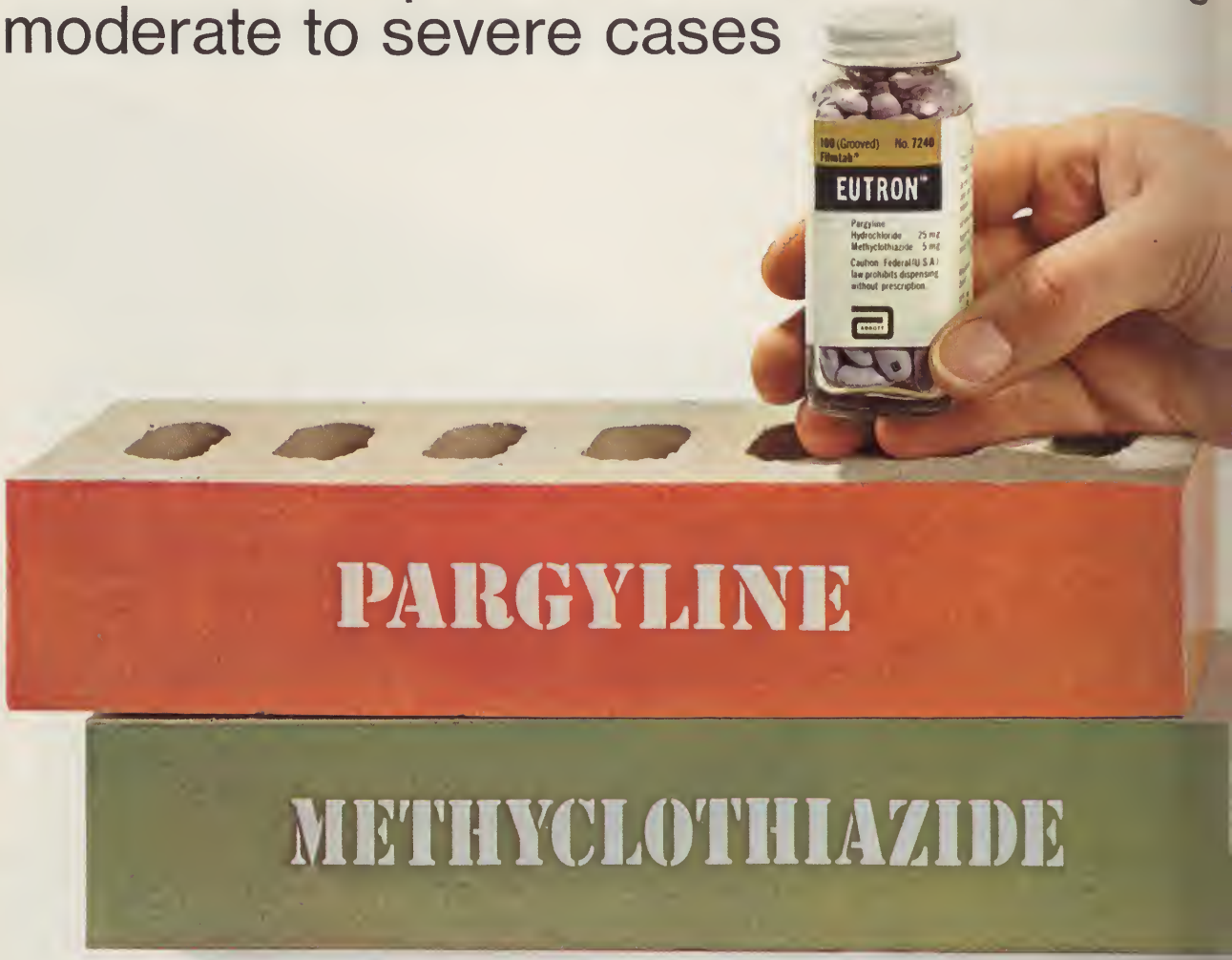
ENDURONYL®

METHYCLOTHIAZIDE 5 mg. with DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.



See Brief Summary on final page of advertisement

Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

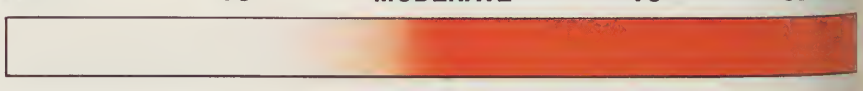
Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

801094

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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MARYLAND STATE DEPARTMENT OF HEALTH

William J. Peeples, MD, MPH, Commissioner

Highlights

Preliminary Report of Governor's Ad Hoc Health Committee

The preliminary report of Governor Agnew's Ad Hoc Health Committee, chaired by Russell A. Nelson, MD, urged the Governor and the Legislature to plan in future years for adequate support of the Maryland Medical Assistance Program, commenting that the recommended cutbacks are a backward step necessitated by limitation in State revenue for the coming fiscal year.

The Committee also recommended that added staff and support be given the Health Department to permit improved administration, and suggested development of demonstration projects to explore new methods of rendering services with a view to greater efficiency in the use of scarce personnel and funds.

The Committee recommended that Hospital Cost Analysis Service be strengthened and given the function of advising on reasonableness of costs in each of the institutions. It also recommended that costs and cost-trends in each of the participating hospitals and related institutions be made public, in the belief that this will have a moderating effect on the rise of costs.

Air Quality Control Division Chief Appointed

Jean J. Schueneman, BS, MPH, will assume the duties of Chief, Division of Air Quality Control, July 1, 1968. Mr. Schueneman leaves the post of Chief of the Criteria and Standards Branch, National Center for Air Pollution Control, U.S. Public Health Service, Cincinnati, Ohio. He received his BS in Civil Engineering from the University of Illinois, and his MPH degree from the University of Michigan.

Promotional Material Prepared by Immunization Project

The Maryland Immunization Project, Division of Communicable Diseases, has produced a series of six direct-mail pieces and six posters, designed to motivate parents to seek immunizations for their children. Amusing cartoons, bright colors, and unusual typography are used to project the message. To date, in cooperation with the Department of Welfare and the Probation Departments of the Courts, more than 112,000 letter stuffers have been mailed with the checks to families receiving Aid for Dependent Children and court-ordered child support payments. They have also been used in industrial payroll envelopes and Health Department mailings.

The 8½" x 11" posters are available in limited quantities for exhibit in health department clinics and physicians' offices, from the Division of Communicable Diseases, State Health Department, 301 West Preston Street, Baltimore, Md. 21201.

Other States and Medical Assistance

A survey by *U.S. News and World Report,* entitled "Free Medicine Out of Hand in the U.S." says: "the only states without problems in Medicaid are those with no programs or limited programs, or where the needy do not yet know about the free medical care.

"Eight states account for 60% of Federal spending on Medicaid—California, Illinois, Massachusetts, Michigan, Minnesota, New York, Pennsylvania, and Wisconsin.

"Of the eight, only Pennsylvania is spending less money than it budgeted. The others are exceeding their Federal estimates for the year ending June 30 by from $9 million to more than $100 million, with the largest figures coming from New York and California."

Darkfield Microscopy Demonstrated

At the April meeting of the Medical and Chirurgical Faculty, the Venereal Disease Section of the Division of Communicable Diseases demonstated the new darkfield microscopy technique for immediate diagnosis of lesion syphilis. The presentation, entitled "Rapid Syphilis Diagnosis," also included other diagnostic and epidemiological services provided by the V–D section and the laboratories, and outlined the treatment schedule approved by the Department.

Serologic Tests for Syphilis

Beginning in January, 1964, the Central Laboratory of the Bureau of Laboratories adopted the highly sensitive Rapid Plasma Reagin (RPR) Card test as the screening test for syphilis, retesting reactive specimens by the established VDRL test. On the finding of any discrepancy between these two tests, the specific Fluorescent Treponemal Antibody test has been performed. (Initially this was the FTA–200 test, replaced in 1967 by the FTA–Absorbed (FTA–ABS) test.) This highly specific test has largely replaced the Treponemal Pallidum Immobilization (TPI) test; these two specific tests may be performed on special request by a physician because of apparent nonspecific or discrepant results.

Laboratory Confirmations of Gonorrhea

More than 11,491 laboratory examinations of smear specimens for gonorrhea were conducted by the 11 laboratories of the Maryland State Health Department during the past fiscal year, with positive findings reported in 2,680 smears, or 23.6%. Positive results were obtained in 1,246, or 32.5%, of the 3,833 culture specimens examined. The smear specimens are a rough indication of the number of male patients; culture specimens of the number of female patients. The figures do not indicate incidence, as they do not include cases diagnosed by means other than Health Department laboratory confirmation.

Health Manpower Training Courses Established

The Community College of Baltimore is expanding its paramedical programs by the addition of four new curricula for the training of dental assistants, dental laboratory technicians, Occupational Therapy Assistants, and X-ray technicians. The Department will furnish technical training and clinical facilities for the Occupational Therapy Assistant program, leading to certification in one year, and to certification plus the Associate of Arts degree in the two-year program. The cooperative curriculum is the first of its kind, and is part of the effort to find creative solutions to the acute health manpower shortage.

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REHABILITATION NOTES

Douglas Carroll, MD, Editor

Measurement of Performance in Rehabilitation*

"The view is often defended that sciences should be built up on clear and sharply defined basal concepts. In actual fact, no science, not even the most exact, begins with such definitions. The true beginning of scientific activity consists rather in describing phenomena and then in proceeding to group, classify and correlate them. Even at the stage of description, it is not possible to avoid applying certain abstract ideas to the material in hand, ideas derived from various sources and certainly not the fruit of the new experience only." [1]

DOUGLAS CARROLL, MD
Chief, Physical Medicine and Rehabilitation
Baltimore City Hospitals

A major public health problem in the United States is the management of patients with chronic diseases. Because of limited facilities and burgeoning numbers of patients, it is essential to recognize those who can benefit from rehabilitation services available. It is proposed to develop a method for generating information that will be useful in predicting the prognosis for life and for improvement in physical and mental function in a wide variety of patients from data collected at initial evaluation. The type of information needed falls in three large classes: First, the diagnosis and prognosis of the disease, impairment or injury; second, the identification and definition of which activities (activities of daily living) the patient can do for himself and which he lacks; and third, an estimation of the patient's orientation and ability to learn.

Definitions

Rehabilitation is a style of medical practice whose goal is maximal physical, emotional, intellectual, social and vocational independence. The methods are eclectic and comprehensive. Its special intellectual endeavor is the study of the adaptation of the person to his disease, impairment and environment; its purpose is the modification of these impairments in the interest of the patient's physical, emotional and social independence. Treatment is based on the development and exploitation of remaining function.

A *disease* is a disturbance in structure or function of an organ, the whole body, the processes of mentation or any combination thereof. The name given to the presumed disturbance in structure or function is called the diagnosis. Diagnoses are symbols, generally a combination of second, third and fourth degree abstractions.[2,3] To say that a patient "has" pernicious anemia, tuberculosis or a myocardial infarction is not only logically untenable, but perpetrates the concept that disease rather than the person is the entity of medical practice.

Diagnose used as a verb is the art or act of determining the nature of a disease (from the Greek—"deciding" = "The decision reached"). The words anatomical, clinical, laboratory, microscopical, physical, pathological are used in conjunction with diagnosis to indicate by what method the diagnosis was made.

Syndrome (Greek—"a running together") is a group of symptoms and signs which when considered together characterize a disease or lesion.

Impairment is the result of a disease or struc-

* This is the second in a series of notes on "Rehabilitation of Chronic Impairments in Adults."

tural disturbance which prevents normal activity. Physicians alone are competent to determine the degree of impairment. Handicap has the same meaning.

Disability is the total social, economic, psychological and impairment deficit of a person. A person with an impairment is not necessarily disabled. There is a tendency to define disability as a reduction in actual or presumed ability to engage in gainful activity.

Selection of Material

A number of complex social and medical decisions go into the selection of patients entering a study series in a Department of Physical Medicine and Rehabilitation.[4,5] The patient must decide he is sick enough to see a physician; the physician must decide the patient is sick enough to come to a hospital; the physician or patient must select a specific hospital; the admitting physician must decide whether the patient needs hospitalization; the ward physician must select those patients he thinks might benefit from treatment in the Department of Physical Medicine and Rehabilitation; and the Director of that Department must decide that therapy is justified.

Because of the complexity of these decisions and different local conditions, it is impossible to expect two series of patients at different hospitals to be similar. Social background is obviously more important in predicting the outcome of rehabilitation than it is in the study of the effectiveness of a drug in an infection, where social factors are usually not of primary importance. For these reasons it seems important to describe in some detail the factors which may affect selection of patients treated in the Department of Physical Medicine and Rehabilitation at the Baltimore City Hospitals.

The population served at the Baltimore City Hospitals is made up of citizens who are on Public Welfare or are medically indigent. This group is elderly and has a high incidence of chronic diseases.

A second point of patient selection occurs at the point of admission. Except for admission of chronic patients, the administration of admissions is exclusively in the hands of the house staff. The house staff is urged to admit all patients where there is any doubt as to whether hospitalization is needed. Generally, during the period of these studies, beds have been available in all services when admission was thought to be necessary.

A major selection of patients for admission is carried out by the Department of Chronic and Community Medicine. This division of the hospital has the function of administering the long-term medical care of welfare patients who cannot be taken care of in the home. These patients are all worked up on an acute medical ward. Most of them are seen in the Department of Physical Medicine and Rehabilitation whether they are thought by the house staff to have rehabilitation potential or not.

The Department of Physical Medicine and Rehabilitation at the Baltimore City Hospitals differs from that in many hospitals in that it is closely associated with the Department of Medicine, and is run by an internist whose special interests are teaching and involving house staff and medical students in all aspects of rehabilitation. A fourth point of selection is made by the Chief of Physical Medicine and Rehabilitation who sees all patients referred. Certain patients are thought to have no potential for improvement, and these are turned down immediately. These are patients with combination of severe physical impairment and without any intellectual ability whatsoever. When it is uncertain whether a patient will benefit, he is put on a trial period for several weeks to observe the outcome of treatment.

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3. Korzibski, A.: Science and Sanity, Science Press Printing Co., Lancaster, Pa., 1933.
4. Mechanic, David: The Concept of Illness Behavior. *J. Chron. Diseases* 15:189, 1962.
5. White, K. L., Williams, T. F. and Greenberg, B. G.: The Ecology of Medical Care. *NEJM* 265:885, 1961.



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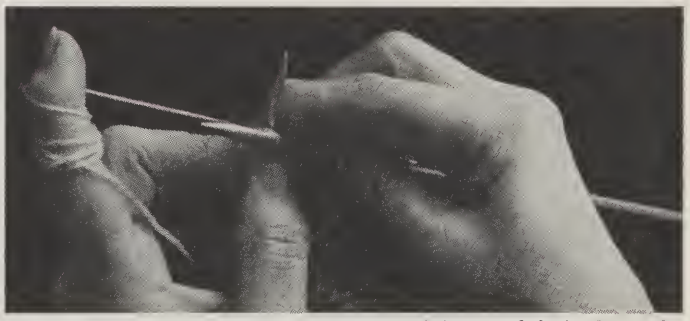
But don't forget this about Butazolidin alka

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.



Dosage in Rheumatoid Arthritis: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response. (B)46-070-A

Butazolidin® alka Geigy

Capsules
phenylbutazone, 100 mg.; dried aluminum hydroxide gel, 100 mg.; magnesium trisilicate, 150 mg.; homatropine methylbromide, 1.25 mg.

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In bacterial/allergic u.r.i., ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the tetracycline-sensitive organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals.
Contraindications: History of hypersensitivity to any component.
Warning: If renal impairment exists, even usual doses may lead to liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Hypersensitive individuals may develop a photodynamic reaction to natural or artificial sunlight during use. Individuals with a history of photosensitivity reactions should avoid direct exposure while under treatment, which should be discontinued at first evidence of skin discomfort.
Precautions: Some individuals may experience drowsiness, anorexia, and slight gastric distress. If excessive drowsiness occurs, it may be necessary to increase the interval between doses. Persons on full dosage should not operate any vehicle. Use may result in overgrowth of nonsusceptible organisms. If infections appear during therapy, appropriate measures should be taken. Infections caused by beta-hemolytic streptococci should be treated for at least 10 full days to help prevent rheumatic fever or acute glomerulonephritis. Use of tetracycline during tooth development may cause discoloration of teeth.
Adverse Reactions: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity; onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels following full therapeutic dosage has been reported. This has disappeared rapidly when drug was discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy and in children given the drug during the neonatal period, infancy, and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Lederle

350-8

BALTIMORE CITY HEALTH DEPARTMENT

Robert E. Farber, MD, MPH, Commissioner

Child Lead Paint Poisoning Still Prevalent

Private physicians and those with hospital assignments, particularly in outpatient or pediatric departments, are reminded that child lead poisoning from ingesting lead paint is still prevalent in Baltimore City. Five children have been stricken since February 29 of this year. All were under three and one-half years of age, the youngest being 24 months.

Any young child with vague and nebulous symptoms should be suspect for lead paint poisoning and should receive a blood test for lead. Blood lead kits are available from the Baltimore

Child Lead Paint Poisoning 1931-1967

	CASES			*DEATHS*		
Year	*Total*	*White*	*Nonwhite*	*Total*	*White*	*Nonwhite*
Total	1,111	203	908	136	46	90
1967	15	4	11	1	1	0
1966	32	2	30	1	0	1
1965	32	4	28	0	0	0
1964	45	3	42	1	0	1
1963	42	7	35	3	0	3
1962	44	3	41	1	0	1
1961	48	4	44	1	0	1
1960	53	9	44	4	1	3
1959	66	2	64	2	1	1
1958	133	17	116	10	3	7
1957	56	4	52	3	2	1
1956	48	8	40	3	1	2
1955	35	5	30	1	—	1
1954	34	8	26	3	1	2
1953	49	10	39	6	3	3
1952	29	6	23	5	2	3
1951	77	20	57	9	3	6
1950	31	2	29	2	—	2
1949	34	11	23	4	1	3
1948	31	4	27	4	1	3
1947	11	1	10	3	1	2
1946	13	7	6	4	2	2
1945	8	4	4	2	1	1
1944	9	5	4	1	—	1
1943	10	3	7	5	2	3
1942	13	1	12	5	—	5
1941	15	4	11	3	2	1
1940	12	3	9	7	—	7
1939	11	6	5	4	3	1
1938	13	9	4	6	4	2
1937	10	7	3	2	1	1
1936	19	12	7	8	4	4
1935	17	2	15	10	2	8
1934	10	4	6	6	2	4
1933	2	1	1	2	1	1
1932	2	1	1	2	1	1
1931	2	—	2	2	—	2

City Branch of the State Health Department Laboratories located in the Municipal Office Building, Lexington and Holliday Streets. Information regarding blood determination may be obtained by calling 752-2000, extension 614.

The following table shows the child lead poisoning cases since records have been kept. While there has been a downward trend since 1958, the drop in cases in 1967 to 15 is believed to be due chiefly to the relatively cool summer last year. The risk of lead encephalopathy is much greater during the warm summer months. Every teething age child who has such initial symptoms as anorexia, apathy, hyperirritability, incoordination and loss of recently acquired skills should be suspect for lead paint poisoning. If lead ingestion continues, the symptoms intensify. Gross ataxia appears together with the classic signs of increased intracranial pressure—projectile vomiting, lethargy, stupor, coma, and convulsions.

Age distribution of the 1,111 cases since 1931 is as follows: Under one year—5; one year—437; two years—491; three years—114; four years—33; five years—17; six years—6; seven years—5; eight years—1; and ten years—2.

While warnings to the public have been issued through the press, radio and TV, the physician who sees young children is in a strategic position to warn "high risk" families of the lead danger and can take appropriate steps if symptoms appear.

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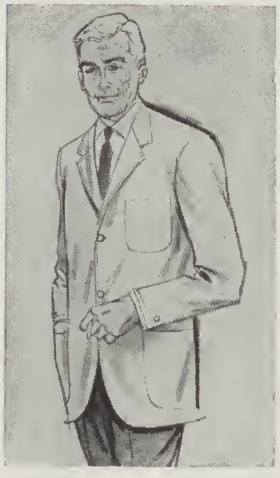
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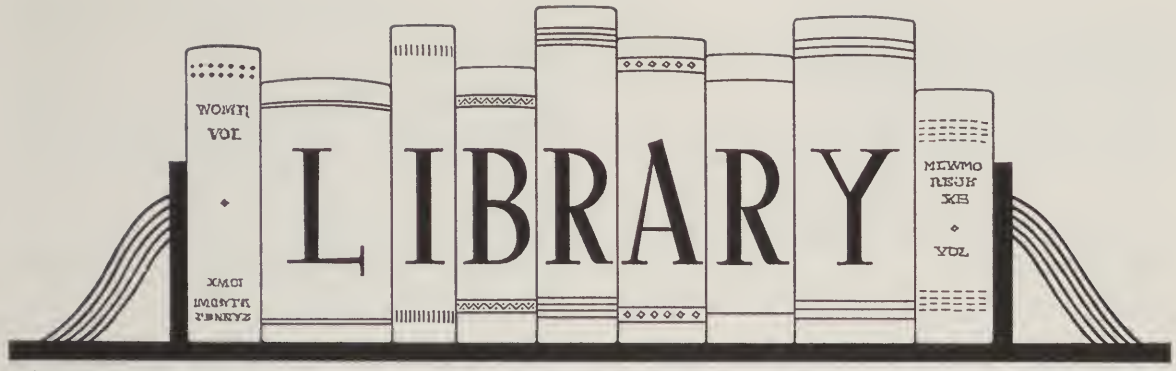


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Paul F. Guerin, MD, Chairman
Library and History Committee

Elizabeth Sanford
Librarian

During the annual meeting of the Medical & Chirurgical Faculty the interest in the books being exhibited was very gratifying. For some of our members this is a once-a-year exposure to the new titles in our library. It is also the best opportunity for the library staff to make contact with the majority of the state's physicians. However, we hope those physicians who were not able to attend the meetings in person will make up for this by either writing or calling the library for special requests.

Another service each physician can do the library is suggesting titles or subjects he wishes added to the collection. This gives the library staff a criteria for acquisitions that contribute to a really live collection.

New Reference Titles

Some of the newer reference books and literature searching tools now available in the library are listed below:

American Medical Association. Archive Library Department.

AMA News cumulated index.

v. 1, 1958 (Aug. 11)—v. 3, 1960 (in 1 volume)—present. Kept up to date annually.

For a medical society library particularly, this index is a valuable source for information practically inaccessible otherwise.

American Medical Association. Archive Library Department.

Index to medical sociocconomic literature.

v. 1, 1962—present. Weekly. Cumulated annually.

Attempts complete coverage of significant literature published in the English language. Over 2200 journals are regularly screened by the library, including books, theses, pamphlets, newspapers, unpublished speeches and other media. These materials are available from the Archive-Library Department, AMA, for research.

American Medical Association.

***Today's Health* cumulated index.**

v. 1, January 1950–1955, v. 2, 1955–1964. (Med-Chi. library lacks v. 1).

Today's Health is a continuation of *Hygeia* which was started by AMA in 1923.

This is a selective index covering main or special articles, editorials, and columns. Subjects and authors are listed in a single alphabetical arrangement, by month, year and page number.

After 1964 the annual index for *Today's Health* is published in the December issue and covers essentially the same references as the cumulated index.

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N. Y., Stuttman, 1964. Family Health Guide edition. (For assistance in answering laymen's questions).

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RA 967 A5 1967	**American Hospital Association.** Guide to Selecting Architects for Hospital Projects. Chicago, American Hospital Association, 1967.
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RA 967 A5 1965	**American Hospital Association. Architectural Exhibition, 1965.** Selected designs; inpatient care units of general hospitals. Chicago, American Hospital Association, 1965.
R 728 A5	**American Medical Association.** The business side of medical practice. Chicago, n.d., American Medical Association in cooperation with Sears, Roebuck Foundation.
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WOMAN'S AUXILIARY

Mrs. Harry L. Berman, Editor

Mrs. H. Leonard Warres, New Auxiliary President

Mrs. H. Leonard Warres was installed as President of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland at the Nineteenth Annual Convention in April after completing her term as President-elect. She has contributed her time and energy to the Woman's Auxiliary to the Baltimore Medical Society since 1959, serving as chairman of the following committees: Medical Research, Membership, Student Aid, Safety, Public Relations, Measles Immunization and many others. She also has been vice-president, president-elect and in 1965 served as president.



Mrs. Warres

Mrs. Warres (Margie) has won distinction in so many fields she has been listed in *Who's Who in American Women.* Born in Philadelphia, Margie matriculated at Goucher College, transferred to Brooklyn College in New York where she received a BA magna cum laude, and was also a recipient of an MSW, from the University of Pennsylvania. In high school she won regional spelling, essay, speech, and declamation contests; graduated Valedictorian and was awarded a charm, which she still wears, for being "Best All Around Girl."

Margie married Dr. Warres in 1939. They have two sons, Stephen, a Princeton graduate now serving in the Peace Corps, and Neil Eric, a high school senior whose beloved violin is never far from his side.

In addition to auxiliary work in the medical societies, Margie is an indefatigable doer in other fields, having served on the following Boards and Committees: Child Study Association, Park School, Hadassah, Green Valley Swimming Club, the Visiting and Nominating Committees of the Levindale Home for the Aged, Sinai Hospital Auxiliary, The National Conference of Christians and Jews, Red Cross, Baltimore Hebrew Congregation and others. In addition, and not the least of her enterprises, is her interest in the Central Scholarship Bureau of which she is Executive Director.

In her inaugural address Margie urged all county auxiliary officers and board chairmen to aim for 100% membership among their doctors' wives. She asked that they make every effort "to discover the unmet needs of their particular communities and attempt to fill such health-related gaps by acting as a catalyst when the auxiliary alone is unequal to a monumental task."

She announced that the first Board Meeting would be at her home on July 12, 1968 and hoped all of her officers and chairmen could be in attendance, full of ideas and set to go-go-go.

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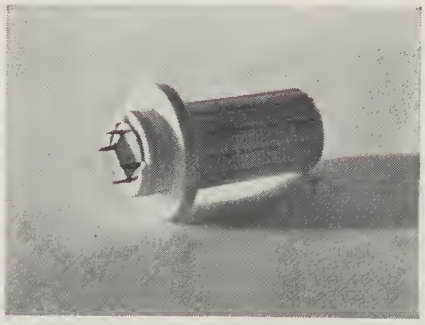
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Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

Lederle

330–8/6135

early relief from DEPRESSION



NORPRAMIN®
(desipramine hydrochloride)

improvement often begins in 2 to 5 days

At the recommended Norpramin (desipramine hydrochloride) dosage level—initially 150 mg. per day—symptomatic improvement may often begin within two to five days. As depression subsides, daytime activity improves . . . mood fluctuations lessen . . . sleep is sounder. Fast onset of action and usually mild side effects are significant reasons for Norpramin's use in depression of any type . . . any degree of severity.

See package insert for complete prescribing information

IN BRIEF:

INDICATIONS: In mental depression of any kind—neurotic or psychotic.

CONTRAINDICATIONS: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease, epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor.

RELATIVE CONTRAINDICATIONS: (1) Patients with a history of paroxysmal tachycardia. (2) Patients receiving concomitant therapy with thyroid, anticholinergics or sympathomimetics may experience potentiation of effects of these drugs. (3) Safety in pregnancy has not been established. (4) Perform liver function studies in patients suspect of having hepatic disease.

PRECAUTIONS: (1) Desipramine hydrochloride should not be substituted for hospitalization when risk of suicide or homicide is considered grave. Suicidal ingestion of large doses may be fatal. (2) If serious adverse effects occur, reduce dosage or alter treatment. (3) In patients with manic-depressive illness a hypomanic state may be induced. (4) Discontinue drug as soon as possible prior to elective surgery.

ADVERSE EFFECTS: The following side effects have been encountered: dry mouth, constipation, dizziness, palpitation, delayed urination, agitation and stimulation ("jumpiness," "nervousness," "anxiety," "insomnia"), bad taste, sensory illusion, tinnitus, sweating, drowsiness, headache, hypotension (orthostatic), flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, tremor, allergy (general), altered liver function, ataxia and extrapyramidal signs, agranulocytosis.

Additional side effects more recently reported include: seizures, eosinophilia, confusional states with hallucinations, purpura, photosensitivity, galactorrhea, gynecomastia, and impotence. Side effects which could occur (analogy to related drugs) include weight gain, heartburn, anorexia, and hand and arm paresthesias.

DOSAGE: Optimal results are obtained at a dosage of 50 mg. t.i.d. (150 mg./day).

SUPPLIED: NORPRAMIN (desipramine hydrochloride) tablets of 25 mg.; bottles of 50, 500 and 1,000; and tablets of 50 mg. in bottles of 30, 250, and 1,000.

LAKESIDE

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

MINUTES OF THE BUSINESS SESSIONS

First Meeting, 170th Annual Session, House of Delegates (260th Meeting)

Medical and Chirurgical Faculty of the State of Maryland

Wednesday, April 17, 1968

The Alcazar, Baltimore, Maryland

The 260th meeting, first of the 170th Annual Session, of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland was called to order at 9:00 A.M., Wednesday, April 17, 1968, at the Alcazar, Baltimore, Maryland, the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance. The asterisk indicates an alternate delegate.

Doctors: Robert T. Adkins, Wicomico County; Manning W. Alden, Council; *Aris T. Allen, Anne Arundel County; Robert G. Angle, Montgomery County; Timothy D. Baker, Baltimore City; John G. Ball, Montgomery County; Harry McB. Beck, Baltimore City; Richard D. Bauer, President; J. Howard Beard, Council; Gerald W. Blanchard, AMA Field Rep.; M. McKendree Boyer, Past President; Wendell J. Burkett, Kent County; Robert vL. Campbell, Past President; Douglas G. Carroll, Baltimore City; *Katharine A. Chapman, Montgomery County; Henry V. Chase, Council; Archie R. Cohen, Council; Ernest I. Cornbrooks, Jr., Baltimore City; Kenneth Cruze, Montgomery County; William B. Culwell, Carroll County; Worth B. Daniels, Baltimore City; H. Vincent Davis, Cecil County; Melvin B. Davis, Baltimore County; John B. DeHoff, Baltimore City; DeWitt E. DeLawter, Montgomery County; J. Sheldon Eastland, Past President; William Carl Ebeling, Council; Emanuel S. Ellison, Baltimore City; Houston S. Everett, Council; James McC. Finney, Harford County; Vincent J. Fiocco, Carroll County; Whitmer B. Firor, Past President; Russell S. Fisher, Council; Harold H. Gist, Washington County; Edward G. Grau, Baltimore County; Paul F. Guerin, Council; J. Roy Guyther, St. Mary's County; William B. Hagan, Council; John C. Harvey, Council; William G. Helfrich, Baltimore City; Thomas F. Herbert, Howard County; Philip W. Heuman, Harford County; Page C. Jett, Calvert County; Frederick M. Johnson, Charles County; Ferd E. Kadan, Baltimore City; D. Frank Kaltreider, Baltimore City; James R. Karns, Baltimore City; Arthur T. Keefe, Jr., Council; Lauriston L. Keown, Baltimore City; Walter N. Kirkman, Council; Edward L. J. Krieg, Baltimore County; Donn Larson, AMA Field Rep.; Henry P. Laughlin, Council; C. Rodney Layton, Queen Anne's County; Leon R. Levitsky, Prince Georges County; William J. McClafferty, Baltimore City; Karl F. Mech, Council; Walter C. Merkel, State Bd. of Med. Ex.; John E. Miller, Baltimore City; Donald W. Mintzer, Baltimore City; Sidney Novenstein, Washington County; Charles F. O'Donnell, Past President; Hilary T. O'Herlihy, Anne Arundel County; William A. Pillsbury, Council; Carolyn S. Pincock, Montgomery County; Harold B. Plummer, Caroline County; J. Emmett Queen, Council; J. Morris Reese, Past President; Guy M. Reeser, Jr., Talbot County; Thomas Reid, Frederick County; William F. Renner, Baltimore City; Philip L. Repetto, Jr., Prince Georges County; Paul F. Richardson, Baltimore City; Peter W. Rieckert, Dorchester County; James A. Roberts, Montgomery County; Raymond C. V. Robinson, Baltimore City; Donald J. Roop, Council; Salvador Rossello, Baltimore City; Edwin R. Ruzicka, Talbot County; John F. Schaefer, Council; Emmanuel Schimunek, Baltimore City; George Simons, Allegany County; Arthur G. Siwinski, Council; Gordon M. Smith, Montgomery County; William G. Speed, III, Council; Andrew Stasko, Allegany County; E. L. Suarez-Murias, Baltimore City; Francis J. Townsend, Jr., Council; Thomas E. Van Metre, Jr., Baltimore City; Emerson Walden, Baltimore City; Lawrence R. Wharton, Jr., Baltimore City; Daniel Wilfson, Jr., Baltimore City; Charles H. Williams, Baltimore County; Ralph H. Williams, Washington County; Donald O. Wood, Baltimore County; Charles E. Wright, Frederick County; John D. Young, Jr., Baltimore City; Raymond M. Yow, Council.

Present also for the meeting were staff personnel.

INVOCATION

The invocation was given by the Reverend Paul J. McCleave, Director, Department of Medicine and Religion of the American Medical Association.

ANNOUNCEMENTS

The President made certain announcements with regard to the conduct of business at the session.

MINUTES

The minutes of the House of Delegates of the September 8, 1967 semiannual session; and the November 11, 1967, special session, having been distributed to the members and having been approved by the Executive Committee, were presented to the House for information. Both sets of minutes were amended to include the name of James McC. Finney, MD, of Harford County, as being in attendance.

NECROLOGY

After the Secretary read the following names of deceased members, the House of Delegates members rose in observance of a moment's silence in respect for their deceased colleagues:

Allegany County

Doerner, Wyand F.	July 21, 1967

Baltimore City

Brown, Webster H.	May 5, 1967
Daniels, Thomas F.	June 3, 1967
Dodson, Claude C.	May 20, 1967
Drozd, Joseph	November 28, 1967
Flippin, Eugene L.	March 17, 1967
Foster, Herbert M.	November 26, 1967

Goldberg, Victor	September 18, 1967
Hart, Jeremiah A.	March 26, 1967
Hogan, John F., Sr.	November 26, 1967
Karns, Clyde F.	August 17, 1967
Klimas, Albinas	January 10, 1968
Marshall, John R.	January 25, 1968
Monninger, Arthur C.	September 29, 1967
Morris, Frank K.	November 9, 1967
Morrison, J. Huff	August 13, 1967
Novey, Samuel	May 23, 1967
Prather, Perry F.	December 23, 1967
Raskin, Moses	April 20, 1967
Rosenfield, Morris	February 17, 1968
Scheye, Henry W.	December 5, 1967
Schwartz, Daniel J.	April 15, 1967
Sherman, Solomon	August 22, 1967
Shiling, Moses S.	June 9, 1967
Singewald, A. G.	March 2, 1968
Smith, Fred B.	January 30, 1968
Volenick, Lee J.	September 12, 1967
Wilder, Milton J.	April 23, 1967
Wolman, Samuel	December 16, 1967
Baltimore County	
Benson, Edward H.	March 22, 1967
Holden, Frederick A.	March 18, 1968
Howell, James G.	May 23, 1967
Dorchester County	
Wolff, Eldridge H.	December 7, 1967
Garrett County	
Baumgartner, E. I.	August 8, 1967
Harford County	
Wolbert, Frank	August 16, 1967
Kent County	
Hamilton, H. H.	October 11, 1967
Joyce, Florence D.	May 2, 1967
Kester, Eugene	December 22, 1967
Montgomery County	
Barrett, Robert J.	October 2, 1967
Miller, William C.	September 26, 1967
Prince Georges County	
Bosworth, Robert J.	June 9, 1967
Conant, James S.	April 9, 1967
Moyers, Waldo B.	December 10, 1967
Queen Anne's County	
Hoyt, Irvin G.	March 31, 1967
Somerset County	
Johnson, Robert H.	March 9, 1967
Talbot County	
Robinson, John N.	November 29, 1967
Washington County	
Dwyer, James R.	July 9, 1967
Whitcomb, David Twining	March 25, 1968
Affiliates	
Futterman, Perry	December 11, 1967
Harrat, Frank T.	March 19, 1967
Hopkins, John V.	December 12, 1967
Welch, William	February 20, 1968

SPECIAL RECOGNITION OF DECEASED MEMBERS

Arthur G. Siwinski, MD, President-elect, offered the following resolutions in memory of distinguished members who had died during the previous year. Each of these resolutions was adopted unanimously.

EUGENE I. BAUMGARTNER, MD 1904–1967

Whereas, Eugene I. Baumgartner, MD, who died on August 8, 1967, served the community of Oakland, Maryland faithfully and well until his death, and

Whereas, He also gave many hours of time beyond the call of duty to the community, to his fellow-physicians and to the cause of medicine generally, and

Whereas, His death caused much grief and sorrow among the physicians of this State and Country, and

Whereas, His activities on a Local, State, and National level will be difficult, if not impossible to replace, and

Whereas, He served conscientiously, devotedly, without thought of himself, in any capacity in which he was asked to serve, and

Whereas, His loss to his fellow-physicians is impossible to define, be it

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland in regular session acknowledges the deep debt of gratitude it owes to Eugene I. Baumgartner, MD, formerly of Oakland, Maryland, and

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland hereby orders this Resolution spread upon the minutes of this House of Delegates meeting, and

Resolved, That a copy of this resolution be sent to his wife, Mrs. Helen Baumgartner, with its expressions of deep sorrow and regret.

* * * * * *

FRANK K. MORRIS, MD 1901–1967

Whereas, Frank K. Morris, MD, was taken from the midst of his colleagues suddenly on November 9, 1967, and

Whereas, His sudden death caused much regret and concern amongst his fellow-physicians, and

Whereas, He had served the medical profession for many years in many ways, among which his tenure on the Board of Medical Examiners was only one outstanding service to mankind, and

Whereas, His abilities and his place will be hard to fill, and

Whereas, Those who serve the public and their fellow-physicians so outstandingly and well, should be specially recognized, be it

Resolved, That this House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland go on record at its regularly convened session as taking due notice of the death of Dr. Morris, and

Resolved, That this House of Delegates hereby pays tribute and expresses its appreciation for the many years of devoted work performed by Dr. Morris on behalf of the public and the profession, and

Resolved, That this House of Delegates orders this resolution spread upon the minutes of this meeting and a copy be sent to Mrs. Margaret Morris and family.

* * * * * *

WALDO B. MOYERS, MD 1900–1967

Whereas, Waldo B. Moyers, MD, affectionately known as "Pop" to his friends and colleagues, was taken from our midst on December 9, 1967, and

Whereas, His death, after a long illness, despite the forewarning, was received with deep regret by all those who knew him, and

Whereas, He had served the medical profession over the years with devotion, understanding and concern, and

Whereas, "Pop" was instrumental in the revitalization

of the Faculty in the 1950's, working long and hard towards its goal of service to the public and its members, and

Whereas, As a school teacher in West Virginia he came to know the youth of the community and to understand their problems, and

Whereas, Because of his compassion and understanding of humans, he realized his proper field was that of medicine which brings relief and succor to man, and

Whereas, On making this decision, he entered the University of Maryland School of Medicine where he was an illustrious student, working diligently in studying for his chosen field, and

Whereas, On graduation he elected to grace the State of Maryland and the County of Prince George where he exercised his many talents from 1933 until shortly before his death, and

Whereas, he was beloved and respected by his patients, his friends, his colleagues and all those with whom he came in contact, be it

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland in regular session held on April 17, 1968, recognize formally the death of one of Maryland's great physicians, and

Resolved, That this House of Delegates hereby acknowledges with appreciation and thanks the efforts expended on behalf of the public and the profession by "Pop", and

Resolved, That this House of Delegates recognizes that the profession owes a deep debt of gratitude for "Pop's" work on its behalf, and

Resolved, That this House of Delegates orders this resolution spread upon the minutes of this meeting and a copy be sent to Mrs. Elinor Moyers and family as a small recognition of its gratitude.

* * * * * *

EMERITUS MEMBERSHIP

On motion of Chairman of the Council, the following members who had received the recommendation of their respective societies and the Council, were elected to Emeritus Membership in the Faculty:

N. Floyd Adams, Jr., MD
S. H. Barranco, MD
J. Wesley Edel, MD
Byruth Lenson-Lambros, MD
Ernest L. Stebbins, MD
J. Douglass Shepperd, MD, all of Baltimore City
Harry Butler, MD, of Baltimore County
Louis R. Lang, MD,
Samuel L. Tabb, MD, both of Montgomery County
William L. Winters, MD, of Talbot County

RESOLUTION HONORING DEAN THOMAS B. TURNER, ON HIS RETIREMENT

William G. Helfrich, MD, on behalf of the Membership Committee, presented the following resolution honoring Dean Thomas B. Turner, MD, of The Johns Hopkins University School of Medicine on the occasion of his retirement as Dean, which was adopted unanimously.

Whereas, Dean Thomas B. Turner, MD, will retire as Dean of The Johns Hopkins Medical School on June 30, 1968, and

Whereas, Dean Turner is admired and respected by all of his colleagues on a Local, State and National level, and

Whereas, Dean Turner has served his fellow-physicians, the public and the community long and well, and

Whereas, Dean Turner in his many voluntary efforts, too numerous to list in this resolution, has brought pride and distinction to the City of Baltimore, the physicians of Maryland, and in turn to the medical institutions located in this state, and

Whereas, A person of such distinction should receive the honor and credits due him, and

Whereas, This House of Delegates of the Medical and Chirurgical Faculty wishes to recognize the outstanding ability, attributes of Thomas B. Turner, MD, be it

Resolved, That this House of Delegates give a standing ovation to Thomas B. Turner, MD, in recognition of its respect and regard for him, and be it

Resolved, That this resolution be spread upon the minutes of this session of the House of Delegates, and be it

Resolved, That this be prepared as a suitably engraved scroll and presented to him as a tribute to him on the occasion of his retirement as Dean of The Johns Hopkins University School of Medicine.

Dr. Turner expressed his appreciation for this honor.

SPECIAL AWARD TO J. G. F. SMITH, MD, BRUNSWICK, MD.

Dr. J. G. F. Smith, of Brunswick, Md., was to have received a special award recognizing his years of service to his community. Dr. Smith was unable to be present, having been slightly injured the day before he was scheduled to be present at this meeting.

PRESENTATION OF FIFTY-YEAR PINS

No Fifty-year pins were presented, because none of the three physicians eligible were able to be on hand.

AWARD OF VIET NAM PLAQUES

The President awarded plaques for voluntary service in Viet Nam under the AMA's program of Volunteer Physicians For Viet Nam to the following:

Michael B. Flynn, MD, Baltimore, Md.
Patrick Reardon, MD, Seabrook, Md.

The House recognized these volunteer physicians by a round of applause.

TREASURER'S AND AUDITOR'S REPORTS

The Treasurer then presented his report for 1967, which had been distributed. The auditor's report was adopted by unanimous consent.

BYLAWS COMMITTEE REPORT

Charles F. O'Donnell, MD, Chairman of the Bylaws Committee, on its behalf, moved the adoption of the following Bylaw amendments which, after debate, were adopted in each case by more than the required two-thirds vote.

(a) Amend Article IV, Section 1, by striking out the figure 17 and inserting the figure 22.

(b) Amend Article IV, Section 3 (c) by substituting for it the following new section:

(c) Central District: Baltimore City, Baltimore and Harford Counties; eleven councilors including at least eight from Baltimore City, two from Baltimore County and one at large.

(c) Amend Article IV, Section 3 (e) by substituting for it the following new section:

(e) South Central District: Montgomery and

Prince Georges Counties; five councilors, three from Montgomery County and two from Prince Georges County.

(d) Amend Article XI, Section 11, by striking out the words "The chairman of the Council and not more than" and inserting the words, "not serving on the Commission on Medical Discipline and at least"

(e) Amend Article XI, Section 25, by adding the following: "and the Mediation Committee."

(f) Amend Article XIII, Section 1 (3) by striking out the words, "against a member by a member" and inserting the words, "against a physician by a physician."

(g) Amend Article XIII by inserting the following new section 2:

"Section 2. Matters referred to the Faculty by the Maryland Commission on Medical Discipline shall be referred to the Mediation Committee for action. The Committee shall upon receipt of such matters forward them to the appropriate component society for initial investigation and report to the Committee. The Committee may conduct such investigation as may be necessary for report to the Commission, said report to contain findings of fact, conclusions of law and recommendations for disciplinary action."

(h) Amend Article XIII, Section 3, by striking out "The Committee's findings and recommendations in the form of resolutions shall be filed with the Council for consideration and action, provided that the Committee may, of its own motion, refer the matter to the Board of Medical Examiners. Any party aggrieved by the action of the Committee," and inserting the following: "The findings and recommendations of the Committee shall be sent to the interested parties. Any party aggrieved by the action of the Committee, except in matters of report to the Commission."

(i) Amend Article XIII, Section 4, by inserting at the beginning of the section the words, "Except in matters for report to the Commission"

Dr. O'Donnell, Bylaws Committee Chairman, on its behalf, moved the adoption of the following amendment to Standing Rule #2, which, after debate, was adopted by a majority vote:

(a) Amend Standing Rule #2 by striking out the words, "their guests" in both paragraphs and inserting "guests of the Faculty."

SUPPLEMENTAL REPORT OF THE BYLAWS COMMITTEE

John G. Ball, MD, Delegate from Montgomery County, requested permission to withdraw the question raised in the Supplementary Report of the Bylaws Committee, and such permission was granted.

NOMINATING COMMITTEE REPORT

J. Morris Reese, MD, Nominating Committee Chairman, presented the following slate:

President-elect
RUSSELL S. FISHER, Baltimore
(President-elect 1968–69)
(President 1969–70)

First Vice-President
MARVIN I. MONES, Silver Spring

Second Vice-President
SAMUEL MORRISON, Baltimore

Third Vice-President
GUY M. REESER, St. Michaels

Secretary
WILLIAM A. PILLSBURY, Timonium

Treasurer
KARL F. MECH, Baltimore

Councilors
ROBERT C. KIMBERLY, Baltimore, Central District (1972)
WILLIAM B. HAGAN, Riverdale, South Central (1972)
MANNING W. ALDEN, Annapolis, Southern (1972)
RICHARD Y. DALRYMPLE, Westminster, Western (1972)
ROBERT J. THOMAS, Frederick, Western (1972)
ARTHUR T. KEEFE, Chestertown, Eastern (1968–1970)
*J. MORRIS REESE, Lutherville, Central (1968–1971)
*JOHN T. CHISSELL, Baltimore, Central (1968–1971)
*JOHN G. BALL, Bethesda, South Central (1968–1971)
*SERUCH T. KIMBLE, Silver Spring, South Central (1968–1971)
*WOLCOTT L. ETIENNE, College Park, South Central (1968–1971)

Delegate to American Medical Association
ROBERT VL. CAMPBELL, Hagerstown (Jan. 1, 1969–Dec. 31, 1971)

Alternate Delegate to American Medical Association
CHARLES F. O'DONNELL, Towson (Jan. 1, 1969–Dec. 31, 1971)

Committee on Program and Arrangements
WILLIAM L. STEWART, Westminster (1973)

Library and History Committee
GEORGE A. MAXWELL, Rockville (1974)

Finney Fund Committee
RICHARD V. HAUVER, Hagerstown (1974)

Board of Medical Examiners
ARCHIE R. COHEN, Clear Spring (June 1968–June 1972)
JOHN J. CURRY, Silver Spring (June 1968–June 1969)
GERALD A. GALVIN, Baltimore (June 1968–June 1971)
KARL F. MECH, Baltimore (June 1968–June 1972)

The floor was opened to further nominations for these offices and there being none, nominations were closed by general consent, the election to be held at the second meeting of the session, Friday, April 19, 1968, at the Faculty building. The nominees for the Board of Medical Examiners are to be elected at the General Session, Thursday, 12:00 Noon, April 18, 1968, at The Alcazar.

*Additional nominees submitted after report of Nominating Committee prepared and after Bylaw amendment adopted by the House of Delegates.

INTRODUCTION OF RESOLUTION 6A/68

Dr. Fisher, Council Chairman, on behalf of the Council, by unanimous consent, introduced Resolution 6A/68, to the House of Delegates with the understanding that it would be considered at the Friday afternoon session, April 19, 1968.

STUDENT AMA PRESIDENT

Mr. John Gelin, President of the University of Maryland Chapter, Student American Medical Association, then addressed the House of Delegates, outlining

briefly the activities and programs of this organization. He thanked the House for the financial support given to it by the Faculty as well as the Baltimore City Medical Society.

MARYLAND MEDICAL POLITICAL ACTION COMMITTEE

Joseph H. Hooper, Jr., MD, President of the Maryland Medical Political Action Committee, addressed the House briefly on the activities of this group during the past year.

MEMBERSHIP COMMITTEE REPORT

Dr. Helfrich, on behalf of the Membership Committee moved adoption of the following recommendation which, after debate, was adopted:

That the Bylaws Committee be directed to draft amendments to allow component societies to admit into membership graduates of Colleges of Osteopathy, who are duly licensed to practice medicine and surgery in Maryland, applying the same standards used in deciding eligibility to membership in the case of a doctor of medicine.

Dr. Helfrich, on behalf of the Membership Committee, moved adoption of the following recommendation which, after debate, was *DEFEATED*:

That the membership applications for the Faculty and its Component Societies require membership applications to certify to the following or similar words, "I hereby agree to confine my practice of medicine to scientific principles, as enunciated by my peers"

Dr. Helfrich, on behalf of the Membership Committee, moved adoption of the following recommendation which, after debate, was adopted:

That the matter of hospital staff membership is a decision for each individual hospital, so that the same standards used by a hospital in deciding whether staff privileges should be extended to a doctor of medicine should be used in deciding whether staff privileges should be given to a doctor of osteopathy and, inasmuch as it is important that each hospital, if at all possible, be accredited by the Joint Commission on Accreditation of Hospitals, the policy laid down by the Joint Commission pertaining to hospitals with integrated staffs should be observed.

EMOTIONAL HEALTH COMMITTEE REPORT

Thurman Mott, MD, Emotional Health Committee chairman, on behalf of the Committee, moved adoption of the following recommendation of the Committee; which, after debate, was adopted unanimously:

Since the abuse of drugs, especially narcotics, is a continuing social problem which contributes significantly toward crime in our communities, it is hereby resolved that a high priority be given by the State Board of Health and Mental Hygiene to the establishment of a drug abuse center for Maryland. The functions of this center would be: (1) to provide a seven-day-a-week consultation service for anyone with a drug problem who makes application; (2) to function as a referral agency to appropriate treatment facilities for such applicants; (3) to provide information service on the subject of drug abuse for physicians as well as the public; and (4) in conjunction with these services maintain a laboratory facility utilizing the most advanced techniques for performing daily urine analyses for the use of city and state agencies, as well as hospitals and physicians, both public and private, who wish to utilize this type of resource in the management of their patients.

POSTGRADUATE EDUCATION, PREVENTIVE MEDICINE AND PUBLIC HEALTH COMMITTEE REPORT

Frederick Heldrich, MD, on behalf of the Committee on Postgraduate Education, Preventive Medicine and Public Health, moved adoption of the following motion which, after debate, was adopted:

The MEDIC network should be continued with supporting funds being provided by either a grant from the United States Public Health Service or drug companies, payable to the Medical and Chirurgical Faculty. The control of the network will remain with the Medical and Chirurgical Faculty, the State Health Department, and the local hospitals. Staff time would be provided on the same basis as is presently done, by the Faculty and the State Health Department.

TREASURER'S RECOMMENDATION ON MEDIC

Dr. Mech, Treasurer, moved that the following motion be adopted which was adopted unanimously by the House:

That the MEDIC network be continued and that sufficient funds be appropriated to the extent needed to finance the operations for the coming MEDIC year.

INFORMATION COMMITTEE REPORTS

The following reports were distributed in writing for the information of the meeting and an opportunity was afforded at this time to raise any questions.

Report of the Delegates to the American Medical Association—
Robert vL. Campbell, MD, J. Sheldon Eastland, MD, Russell S. Fisher, MD, December, 1967, Clinical Meeting
Secretary—William A. Pillsbury, MD
Board of Medical Examiners—Walter C. Merkel, MD, Secretary
Executive Secretary—Mr. John Sargeant
Library and History Committee and Finney Fund Committee—Paul F. Guerin, MD, and D. C. W. Finney, MD
Curator—Edwin David Weinberg, MD
Committee on Program and Arrangements—Thaddeus E. Prout, MD
Committee on Contractual Arrangements—Belden R. Reap, MD
Medical Economics Committee—W. Kenneth Mansfield, MD
Editorial Board, Maryland State Medical Journal—C. Thomas Flotte, MD
Finance Committee—Karl F. Mech, MD
Legislative Committee—B. Martin Middleton, MD
Liaison Committee—William L. Stewart, MD
Maryland Medical Service, Board of Trustees—J. Sheldon Eastland, MD, President
Med-Chi Insurance Trust—Paul F. Guerin, MD
Mediation Committee—Wolcott L. Etienne, MD
Medical Emergency Disaster Service Committee—Charles J. Savarese, MD
Medicolegal Committee—Robert W. Johnson, III, MD
Occupational Health Committee—John R. Davis, MD
Policy and Planning Committee
Professional Medical Services—William G. Speed, III, MD
Public Relations Committee—Robert B. Goldstein, MD
Representatives on the Medical Advisory Committee of the Red Cross Blood Bank Program.

ANNOUNCEMENTS

The Chair recognized W. Kenneth Mansfield, MD, who made an announcement dealing with a meeting scheduled for June 15, 1968, at Eastwind on, "The Physician's Role in the Rising Cost of Hospitalization."

The Chair recognized William J. Peeples, MD, State Health Commissioner, who outlined the background leading to publication of physicians' names and amounts of money paid for services rendered in Maryland's Medical Assistance Program.

LEGISLATIVE ACTIVITY COMMENDATION

Dr. Mech asked the House to recognize the yeoman service given by those persons who represented the Faculty during the recently concluded session of the General Assembly. The House formally recognized these contributions of B. Martin Middleton, MD, Legislative Chairman; J. Morris Reese, MD, Past-president; and Mr. John Sargeant, Executive Secretary; as well as others who assisted in many ways.

There being no further business, the meeting was adjourned at 11:20 A.M.

WILLIAM PILLSBURY, MD, *Secretary*

ELECTION OF THE BOARD OF MEDICAL EXAMINERS

General Meeting
Thursday, April 18, 1968

A general meeting of the Medical and Chirurgical Faculty of the State of Maryland was held on Thursday, April 18, 1968, at 12:00 Noon, at the Alcazar, Cathedral and Madison Streets, Baltimore, Md., 21201, for the purpose of electing members of the Board of Medical Examiners as follows:

two, for a four-year term
one, for a three-year term
one, for a one-year term

The President, Richard D. Bauer, MD, presided and called the meeting to order at 12:00 Noon.

The names of the nominees for the posts shown were presented to the General Meeting as follows:

Karl F. Mech, MD, Baltimore
Archie R. Cohen, MD, Hagerstown
for four-year terms commencing June 1, 1968
Gerald A. Galvin, MD, Baltimore
for three-year term commencing June 1, 1968
John J. Curry, MD, Silver Spring
for one-year term commencing June 1, 1968

Nominations from the floor were requested. There being none, the President declared nominations closed.

Election took place by acclamation and the Secretary, William A. Pillsbury, MD, was instructed to cast one ballot for those nominated.

There being no further business, the meeting adjourned at 12:05 P.M.

WILLIAM A. PILLSBURY, MD, *Secretary*

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11 A.M.—11 P.M.
CLOSED MONDAY

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MINUTES OF THE BUSINESS SESSIONS

Second Meeting, 170th Annual Session, House of Delegates (261st meeting)

Medical and Chirurgical Faculty of the State of Maryland Friday, April 19, 1968

The 261st meeting, second of the 170th annual session, of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland, was held at the Faculty building, 1211 Cathedral St., Baltimore, Maryland at 2:00 P.M., on Friday, April 19, 1968.

The following delegates (or alternates) were registered as being in attendance; an asterisk indicates an alternate delegate:

Doctors: Manning W. Alden, Council; Robert G. Angle, Montgomery County; *Samuel N. Bacon, Jr., Baltimore County; Timothy D. Baker, Baltimore City; John G. Ball, Montgomery County; Harry McB. Beck, Baltimore City; Richard D. Bauer, President; Gerald W. Blanchard, AMA Field Rep.; M. McKendree Boyer, Past President; Wendell J. Burkett, Kent County; Robert vL. Campbell, Past President; Henry V. Chase, Council; Archie R. Cohen, Council; Ernest I. Cornbrooks, Jr., Baltimore City; Kenneth Cruze, Montgomery County; William B. Culwell, Carroll County; Worth B. Daniels, Baltimore City; Melvin B. Davis, Baltimore County; John B. De Hoff, Baltimore City; J. Sheldon Eastland, Past President; William Carl Ebeling, Council; Emanuel S. Ellison, Baltimore City; Houston S. Everett, Council; James McC. Finney, Harford County; Vincent J. Fiocco, Carroll County; Whitmer B. Firor, Past President; Russell S. Fisher, Council; Harold H. Gist, Washington County; Gina M. Glick, Allegany County; Paul F. Guerin, Council; William B. Hagan, Council; John C. Harvey, Council; William G. Helfrich, Baltimore City; Thomas F. Herbert, Howard County; William T. Joyce, Montgomery County; Ferd E. Kadan, Baltimore City; D. Frank Kaltreider, Baltimore City; James R. Karns, Baltimore City; Arthur T. Keefe, Jr., Council; Lauriston L. Keown, Baltimore City; Robert C. Kimberly, Council; Edward L. J. Krieg, Baltimore County; Donn Larson, AMA Field Rep.; C. Rodney Layton, Queen Anne's County; Herbert H. Leighton, Garrett County; Norman Levin, Baltimore City; Leon R. Levitsky, Prince Georges County; William J. McClafferty, Baltimore City; Karl F. Mech, Council; B. Martin Middleton, Council; John E. Miller, Baltimore City; Donald W. Mintzer, Baltimore City; Clayton Norton, Anne Arundel County; Sidney Novenstein, Washington County; Charles F. O'Donnell, Past President; Hilary T. O'Herlihy, Anne Arundel County; J. Emmett Queen, Council; J. Morris Reese, Past President; Guy M. Reeser, Jr., Talbot County; Harry G. Reeves, Wicomico County; *Talmadge C. Reeves, Wicomico County; Thomas Reid, Frederick County; William F. Renner, Baltimore City; Paul F. Richardson, Baltimore City; Peter W. Rieckert, Dorchester County; *Martin A. Robbins, Baltimore City; *James A. Roberts, Montgomery County; Donald J. Roop, Council; Salvador Rossello, Baltimore City; Edwin R. Ruzicka, Talbot County; Peter A. Santucci, Montgomery County; John F. Schaefer, Council; Emmanuel Schimunek, Baltimore City; George Simons, Allegany County; Arthur G. Siwinski, Council; R. Kennedy Skipton, Prince Georges County; Gordon M. Smith, Montgomery County; William G. Speed, III, Council; Martin E. Strobel, Baltimore County; E. L. Suarez-Murias, Baltimore City; Aaron H. Traum, Montgomery County; Thomas E. Van Metre, Jr., Baltimore City; Emerson Walden, Baltimore City; Lawrence R. Wharton, Jr., Baltimore City; Daniel Wilfson, Jr., Baltimore City; Donald O. Wood, Baltimore County; *Arthur F. Woodward, Montgomery County; Charles E. Wright, Frederick County; Raymond M. Yow, Council.

Present also for the meeting were staff personnel.

ELECTION OF OFFICERS

There being no candidates nominated from the floor and there being only one candidate for each of the positions to be filled, by unanimous consent the ballot was dispensed with.

President-elect
RUSSELL S. FISHER, Baltimore
(President-elect 1968–69)
(President 1969–70)

First Vice-President
MARVIN I. MONES, Silver Spring

Second Vice-President
SAMUEL MORRISON, Baltimore

Third Vice-President
GUY M. REESER, St. Michaels

Secretary
WILLIAM A. PILLSBURY, Timonium

Treasurer
KARL F. MECH, Baltimore

Councilors
ROBERT C. KIMBERLY, Baltimore, Central District (1972)
WILLIAM B. HAGAN, Riverdale, South Central (1972)
MANNING W. ALDEN, Annapolis, Southern (1972)
RICHARD Y. DALRYMPLE, Westminster, Western (1972)
ROBERT J. THOMAS, Frederick, Western (1972)
ARTHUR T. KEEFE, Chestertown, Eastern (1968–1970)
J. MORRIS REESE, Lutherville, Central (1968–71)
JOHN T. CHISSELL, Baltimore, Central (1968–71)
JOHN G. BALL, Bethesda, South Central (1968–71)
SERUCH T. KIMBLE, Silver Spring, South Central (1968–71)
WOLCOTT L. ETIENNE, College Park, South Central (1968–71)

Delegate to American Medical Association
ROBERT vL. CAMPBELL, Hagerstown
(Jan. 1, 1969–Dec. 31, 1971)

Alternate Delegate to American Medical Association
CHARLES F. O'DONNELL, Towson
(Jan. 1, 1969–Dec. 31, 1971)

Committee on Program and Arrangements
WILLIAM L. STEWART, Westminster (1973)

Library and History Committee
GEORGE A. MAXWELL, Rockville (1974)
Finney Fund Committee
RICHARD V. HAUVER, Hagerstown (1974)

BOARD OF MEDICAL EXAMINERS ELECTION

The President advised the House that members of the Board of Medical Examiners had been elected in a General Session held on Thursday, April 18, as follows:

Archie R. Cohen, MD, Clear Spring, 1968–72
John J. Curry, MD, Silver Spring, 1968–69
Gerald A. Galvin, MD, Baltimore, 1968–71
Karl F. Mech, MD, Baltimore, 1968–72

WEST VIRGINIA MEDICAL SOCIETY PRESIDENT

Richard V. Lynch, Jr., MD, President of the West Virginia Medical Society, brought greetings to the Faculty's House of Delegates from that group.

VIET NAM PLAQUE PRESENTATION

The chair presented a Viet Nam Plaque to Louis Padovano, MD, of Woodstock, Md., on behalf of the AMA and its Volunteer Physician for Viet Nam program.

RECOGNITION OF COUNCIL CHAIRMAN

The Chair recognized Donald J. Roop, MD, who presented a resolution in recognition of the services of Russell S. Fisher, MD, Council Chairman, during the past five years, which was unanimously adopted.

WOMAN'S AUXILIARY REPORT

Mrs. Louise Stone, President of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland, requested permission of the House to speak before it. There being no objection, permission was granted.

Mrs. Stone then read a report of the activities of the Auxiliary during the past year.

PRESIDENT-ELECT OF WOMAN'S AUXILIARY

Mrs. H. Leonard Warres, President-elect of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland, asked permission to address the House. There being no objection, permission was granted.

Mrs. Warres, after introductory remarks, presented a motion for the consideration of the House. After debate, the motion as follows was referred to the Policy and Planning Committee for study and report to the Semiannual session of the House of Delegates:

"That it is the sense of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland that the Woman's Auxiliary of the Medical and Chirurgical Faculty should be accorded 100% membership of all wives of members of the Faculty, including Active, Emeritus, Forty-Year, Associate; as well as widows of former members of the Faculty; and that to accomplish this a Bylaw amendment be presented to the House of Delegates for consideration at its 1968 Semiannual Session providing for such privilege of 100% membership, with such policy taking effect in 1969."

REFERENCE COMMITTEE REPORT

Manning W. Alden, MD, on behalf of the Reference Committee presented its report and on behalf of the Committee recommended that Resolution 1A/68 NOT be adopted.

RESOLUTION 1A/68 REJECTED

The House on a division vote of 27 affirmative and 36 in the negative, rejected Resolution 1A/68, which read as follows:

Whereas, Maryland Medical Service, Incorporated, indicates in its Participating Physicians, Manual, at page 26 (Rev. 2–66) that benefits will be available to its subscribers for diagnostic X-ray services only when such services are performed by physicians conforming to certain criteria established by Maryland Medical Service, Incorporated; and

Whereas, The proper practice of medicine requires the exercise of all of a physician's skills and qualifications; and

Whereas, The condoning of such regulation of medical practice by economic means may lead to further propagation of such restrictions, which are contrary to the best interest of the patient; and

Whereas, Such restrictions are not imposed upon Maryland physicians by licensure; now, therefore, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland condemns any attempt by any insurance company to determine for its subscribers which duly licensed physician is qualified to perform what medical procedure and requests that all insurance carriers doing business in this State amend their regulations accordingly.

RESOLUTION 2A/68 ADOPTED

Dr. Alden, on behalf of the Reference Committee, moved adoption of Resolution 2A/68. The House adopted Resolution 2A/68 which read as follows:

Whereas, The Medical and Chirurgical Faculty of the State of Maryland in special session held in 1939 adopted a report of a special committee that recommended the establishment by state law of the Department of Post-Mortem Examiners; and

Whereas, This report gave, among other reasons for such a separate department, that its composition consisting of the Professor of Pathology at The Johns Hopkins University School of Medicine, the Professor of Pathology at the University of Maryland School of Medicine, the State Health Commissioner, the Baltimore City Health Commissioner and the *Superintendent of the Maryland State Police, would be nonpartisan and non-political; and

Whereas, The State Legislature in 1939 adopted such a law which has, with minor amendments, served the citizens of Maryland well; and

Whereas, The Governor's Task Force to Study the Modernization of the Executive Branch of the State Government (Curlett Commission appointed by Gov. Tawes) has recommended that the function of the Department of Post-Mortem Examiners should be delegated to the Health Department; and

Whereas, The Report of the Committee on the Executive Branch of the Constitutional Convention indicated that the Executive Reorganization of the State Government would not require the Department of Post-Mortem Examiners to be absorbed into another agency of the State Government and that it could continue to operate as it has in the past; and

Whereas, Any change in the present organization of the Department of Post-Mortem Examiners would work to the detriment of the State in its capacity of ascertaining the cause of unexplained deaths, or deaths as a result of violence, suicide, casualty or suddenly when in apparent health or when unattended by a

physician or in any suspicious or unusual manner; therefore, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland goes on record as strongly supporting the principle of the Department of Post-Mortem Examiners remaining an autonomous agency of the State Government and that it not be absorbed into another agency.

*In the original report this was the Attorney-General but this was changed to read Superintendent of the Maryland State Police before presentation to the House.

RESOLUTION 3A/68 RULED OUT OF ORDER

Dr. Alden, of the Reference Committee, recommended that Resolution 3A/68 be referred to the Bylaws Committee for its consideration and report to the House of Delegates.

The Chair ruled this resolution out of order since a change of the type set forth in the resolution would require amendment to the Bylaws under the applicable provisions of the Bylaws as to notice and vote required. The resolution, which read as follows, was without objection referred to the Bylaws Committee:

Whereas, The Bylaws, as amended, make it mandatory that the benefits of Physicians' Defense be denied any physician failing to pay his dues and assessments by January 31st each year; and

Whereas, Manifest injustice may result from a strict application of the Physicians' Defense section of the present Bylaws; and

Whereas, The ends of justice and fair play may be better served by authorizing the Council of the Medical and Chirurgical Faculty to waive the deadline of January 31st in individual cases for good and proper cause; therefore be it

Resolved, That the House of Delegates declares it to be Faculty policy, and hereby authorizes the Faculty Council, for demonstrated good cause in individual instances to waive the mandatory cut-off date for eligibility for Physicians' Defense.

RESOLUTION 4A/68 REFERRED TO POLICY AND PLANNING COMMITTEE

Dr. Alden, on behalf of the Reference Committee moved that Resolution 4A/68 be referred to the Policy and Planning Committee for study and report to the House of Delegates at the Semiannual session.

The House adopted the motion that Resolution 4A/68 be referred to the Policy and Planning Committee for study and report to the House of Delegates at the Semiannual meeting. The resolution read as follows:

Whereas, Incorporation of self-employed persons is an established practice in 35 States at this time; and

Whereas, The right of an individual physician to incorporate his medical practice in Maryland, when deemed personally desirable, should not be denied; now, therefore, be it

Resolved, That the membership of the Medical and Chirurgical Faculty of the State of Maryland endorses and supports the principle of incorporation of self-employed persons at the option of the individual; and be it further

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of Maryland reverse its previous position taken in September 1962, and now favorably endorse the incorporation of self-employed persons.

RESOLUTION 5A/68 ADOPTED

Dr. Alden, on behalf of the Reference Committee, moved that Resolution 5A/68 be adopted. The House adopted Resolution 5A/68, which read as follows:

Whereas, Public Law 89–97, Section XVIII, Part B, of the Social Security Law, provides for payment of physicians' services through a monthly payment by the patient matched by an equal payment from the Federal Government; and

Whereas, Under new provisions of this same law passed by the 90th U.S. Congress, patients may be paid by the carrier (Blue Shield in Maryland) on presentation of a physicians' itemized, NON-Receipted bill, and

Whereas, It is no longer necessary for the physician to accept an assignment in order to receive payment from those patients who do not have funds immediately available; and

Whereas, One system of payment will serve to aid the carrier in processing claims; and

Whereas, Continued acceptance of assignments can easily lead to the setting of physicians' fees by the Federal Government; now, therefore, be it

Resolved, That the physicians of Maryland be encouraged not to accept assignments but to charge their usual and customary fees, allowing their patients to submit itemized bills or statements to the carrier for payment to the patient.

RESOLUTION OF COMMENDATION ADOPTED

J. Morris Reese, MD, requested the permission of the chair to introduce a resolution of commendation of the Executive Secretary; and moved that it be adopted. The House adopted this resolution which read as follows:

Whereas, The occasion of the 170th Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland marks the tenth year of service to the Faculty by Mr. John Sargeant, Executive Secretary; and

Whereas, Through his efforts and untiring devotion to the Faculty and its members, there has been a steady and recognizable growth and expansion of this organization; and

Whereas, He has given unstintingly of his time and energies to the programs and development of this worthy organization; be it therefore

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland hereby recognizes and expresses appreciation and gratitude to John Sargeant for his loyal service; and be it further

Resolved, That this resolution be written into the minutes of this session of the House of Delegates of the 170th Annual Meeting of the Faculty and made a part of the records thereof.

RESOLUTION 6A/68 REFERRED TO REFERENCE COMMITTEE

The House considered Resolution 6A/68, and after debate and the offering of several editorial changes, none of which were adopted, referred the Resolution by a division vote of 44 affirmative, 30 negative to the Reference Committee for consideration and report to the House of Delegates at the Semiannual session. Resolution 6A/68 read as follows:

Whereas, Physicians have traditionally given of their services freely and willingly to those unable to pay for them; and

Whereas, The United States Congress has determined that physicians will be paid for their services rendered to those eligible under Title 19, PL 89–97, and has issued regulations stating that this must commence on July 1, 1967; and

Whereas, Many States, including Maryland, are reluctant to provide the needed funds for these services, services which have been provided over the years at no cost to the government; and

Whereas, The United States Department of Health, Education and Welfare has decreed:

Para. D–5330–2. Handbook of Public Assistance Administration

> "Participating practitioners include sufficient members of each profession, and a proportionate number of practitioners qualified for specialty practice within professions, so that the items of medical care and services included in the plan are available to eligible persons at least to the extent they are available to the general population. As a minimum, the participation ratio determined separately for each profession, and for specialties within a profession, should be approximately two-thirds of such practitioners in the State."; and

Whereas, Determinations as to the services, persons covered, and the rules under which medical care is provided are being reached without adequate consultation with the providers of the services; and

Whereas, Inadequate information provided to Legislators has led the public to believe there was abuse of the program by physicians—but interestingly enough no criticism, charges or other allegations against other providers of health services; and

Whereas, The Medical and Chirurgical Faculty of the State of Maryland believes it was not the intent of the United States Congress to continue to have health care provided our needy citizens on a hit or miss basis; be it therefore

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland hereby pledges the physicians of Maryland to provide health care to needy and near-needy citizens without payment whatsoever; and be it

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland believes that minimum standards provided for in Federal Legislation and Regulations; as well as a requirement that annual improvements be made in programs offered by the various states, are all realistic; and be it

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland urges its members to provide needed health services to needy and near-needy citizens BUT THAT PHYSICIANS SUBMIT NO BILLS FOR THESE SERVICES TO THE STATE HEALTH DEPARTMENT UNTIL SUCH TIME AS ADEQUATE CONSULTATION, ADMINISTRATION AND PROVISION FOR PAYMENT IS ARRANGED WITH THE PHYSICIANS OF MARYLAND; and be it

Resolved, That by this action it is known that physicians are not participating in the Title 19 program as it presently exists in the State of Maryland; and be it

Resolved, Copies of this declaration be sent to all those officials concerned with the operation of the Program.

REPORT OF THE AD HOC COMMITTEE TO REVISE THE MEDICAL PRACTICE ACT

The chair brought the attention of the House to the Report of the Ad Hoc Committee to Revise the Medical Practice Act which was distributed to the House membership. This item will be considered at the Semiannual session of the House of Delegates; no action is necessary.

REQUEST OF COUNCIL TO CONSIDER UNDERTAKING ANOTHER MANAGEMENT STUDY OF FACULTY OPERATIONS

John G. Ball, MD, offered a motion that the House of Delegates request the Council to undertake another survey of the administrative structure of the Faculty by a firm of management consultants, due to the increase in membership in the Faculty and activities and functions of the Faculty since the last management study.

On division vote this was lost, 27 in the affirmative, 36 in the negative.

PROPOSAL FOR BYLAW AMENDMENT TO PROVIDE AUTOMATIC CHANGES IN COUNCIL MEMBERSHIP AS CHANGES IN COMPONENT MEMBERSHIP OCCUR

M. McKendree Boyer, MD, offered a motion that the Bylaws Committee study and develop a mechanism to provide for automatic changes in Council membership, as component membership changes; similar to the mechanism used for computation of House of Delegates membership; with a report to be submitted to the Semiannual session of the Faculty's House of Delegates.

This motion was adopted.

ANNOUNCEMENTS

The Chair made certain announcements and then expressed appreciation for the privilege of serving as President of the Faculty during the past year.

NEW PRESIDENT

The Chair then introduced Arthur G. Siwinski, MD, new Faculty President, who assumed the chair.

ADJOURNMENT

After comments and acceptance remarks, the new President, by unanimous consent, declared the House adjourned *sine die,* at 4:10 P.M.

William Carl Ebeling, MD, *Secretary, Pro Tem*

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Presentation of Awards During Annual Meeting



Richard D. Bauer, MD (left), outgoing President of the Faculty, congratulates J. Morris Reese, MD, immediate Past-President, during the presentation of the Past-President's plaque at the Annual Presidential Dinner, April 18 in Baltimore.



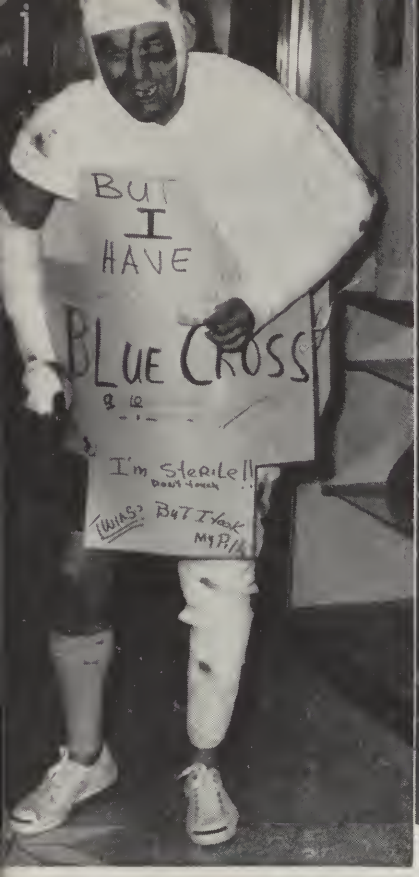
Michael J. Flynn, MD, and Patrick J. Reardon, MD (left to right) receive awards for their 90-day tour of voluntary service in Viet Nam from Dr. Bauer. The voluntary service program is sponsored by the American Medical Association which recruits physicians for 90-day tours to assist Viet Nam civilians.



Vincent O. Eareckson, Jr., MD (right) is the 1968 recipient of the Community Service Award. The presentation was made by Dr. Bauer at the Presidential Dinner. Dr. Eareckson, a prominent ophthalmologist in Talbot County, was saluted this year by his fellow physicians for his community activities. He is a church organist, lay speaker in the Methodist Church, and co-founder and president of a home for delinquent boys just to mention a few.



Charles L. Morreels, Jr., MD, stands in front of his scientific exhibit on Homocystinuria which rated the Aesculapius Award for the Outstanding Scientific Exhibit at the Faculty's Annual Meeting in April. The annual award includes a $200 check and a plaque.









THE LIGHTER SIDE OF ANNUAL MEETING—The Caribbean Cruise Convention: (Clockwise from the top) One of the winners on board the SS Argentina was Theodore Patterson, MD, who bravely administered his ills while waiting for his Blue Cross check to arrive; Dr. and Mrs. Arthur G. Siwinski cut a mean rug in between courses; Thaddeus E. Prout, MD, presided over the scientific sessions and is shown introducing outgoing president, Richard D. Bauer, MD; Mrs. Bauer turned into a beguiling scarecrow and garnered a prize for her efforts; and the attentive attitude of the audience below betrays the interest with which the scientific sessions were met during the cruise.



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In narrative, capsule and outline form the pamphlet highlights major services and materials available from the AMA, lists reference books, enumerates services and publications available on practice management, physician-patient relations and community service, and calls attention to a wide variety of other materials and services provided for members.

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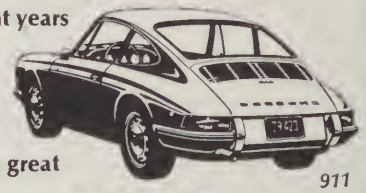
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"Determination of Need for Medical Evaluation in Driver Licensing"

A new attack has been launched on the problem of providing a more adequate method of determining the fitness of applicants for driver's licenses. The spearhead of the attack is a new guide, "Determination of Need for Medical Evaluation in Driver Licensing," just developed by the AMA Committee on Medical Aspects of Automotive Safety.

This guide, aimed at non-medical licensing authorities, suggests a screening procedure to be used on all license applicants, with only those seeming to present an unwarranted risk as drivers being required to have an examination by a physician. To do such screening effectively, lay licensing authorities will have to have medical advice and guidance. The Committee on Medical Aspects of Automotive Safety suggests that state medical association committees on automotive safety work very closely with state licensing authorities and also with county medical societies.

In addition to improving licensing procedures, the AMA Committee feels that this new guide will go a long way toward eliminating agitation for legislation which would require medical examinations for *all* drivers, as well as that which proposes compulsory reporting by physicians of conditions in their patients which might make driving unsafe. Both of these principles have been opposed by the medical profession for many reasons, principally that they are unworkable. In addition, the compulsory reporting proposal is felt to interfere with the confidentiality of medical records as well as with the traditional physician-patient relationship.

"Determination of Need for Medical Evaluation in Driver Licensing" was published originally in the March 4th issue of The Journal of the American Medical Association, and reprints were distributed April 5 to state medical associations. Individual copies may be obtained from the Committee on Medical Aspects of Automotive Safety, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.



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Warnings: Not of value in treatment of psychotic patients, and should not be employed in lieu of appropriate treatment. As with most CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may also be associated with temporary increase in frequency and/or severity of seizures. Advise patients against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance. Keep addiction-prone individuals (such as drug addicts or alcoholics) under careful surveillance because of their predisposition to habituation and dependence. Use of any drug in pregnancy, lactation or in women of childbearing age requires that potential benefit be weighed against possible hazard.

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Adverse Reactions: Side effects most commonly reported: drowsiness, fatigue and ataxia. Infrequently encountered: confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo and blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, use of the drug should be discontinued. Because of isolated reports of neutropenia and jaundice, periodic blood counts and liver function tests are advisable during long-term therapy. Minor changes in EEG patterns (low-voltage fast activity) observed during and after therapy and are of no known significance.

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JULY 1968

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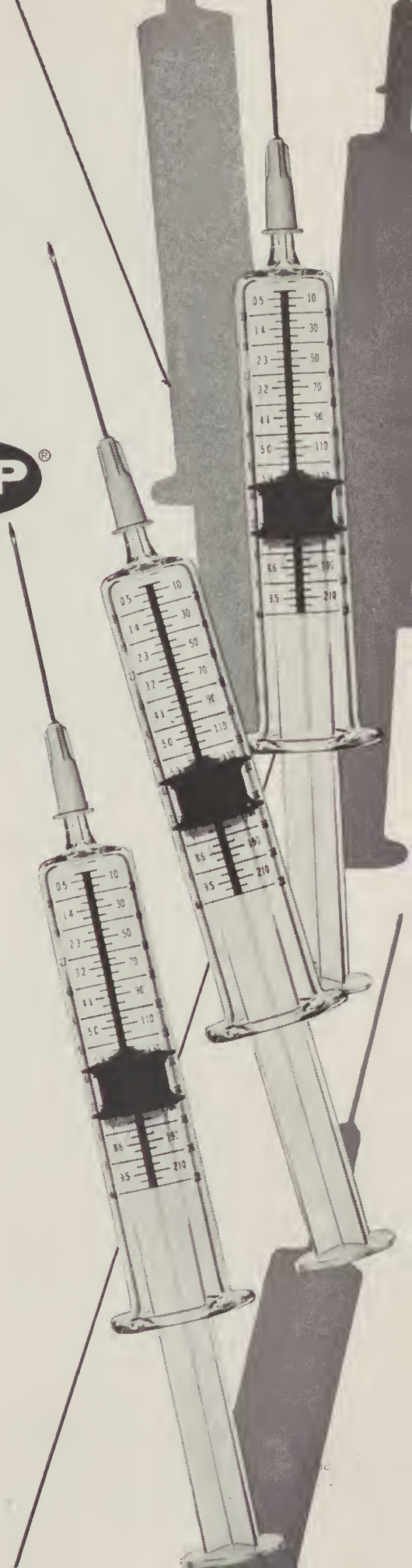
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Editorial and Business Office: 1211 Cathedral Street, Baltimore, Maryland 21201. 539-0872 (Area Code 301)

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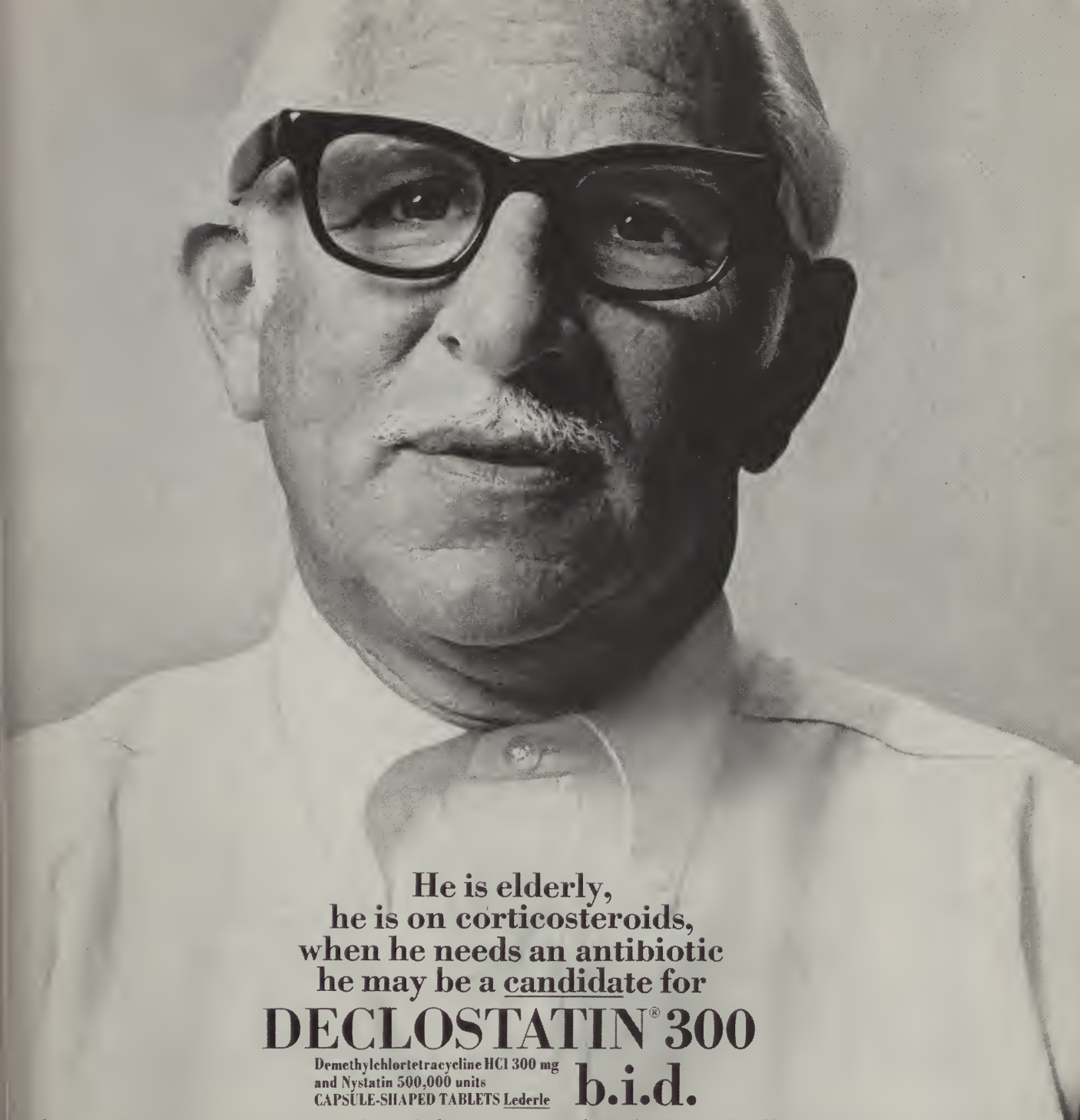
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(see page 90)

Baltimore City Medical Society

Nine members of the Board of Directors of the Baltimore City Medical Society attended the regularly scheduled monthly meeting on Tuesday, May 14, 1968 at 4:30 P.M. at 1211 Cathedral Street, Baltimore. The meeting was called to order by the President, D. Frank Kaltreider, MD.

Departing from the agenda, Dr. Kaltreider informed the Board that Mrs. Lucie Maguire, a long-time employee of the Baltimore City Medical Society, was forced to retire unexpectedly for personal reasons. In addition, Mrs. Dolores Janos is also unable to continue as a secretary for the Society and plans to leave in mid June. The Board approved the appointment of Mrs. Bernadette Silk as the new secretary to the Baltimore City Medical Society and authorized Dr. Kaltreider to make any arrangements he sees necessary for the adequate fulfillment of the Society's secretarial staff.

The minutes of the April 23rd meeting were approved as distributed.

The next item on the agenda was a recommendation introduced by John C. Harvey, MD at a Medical Care Meeting of the Baltimore City Medical Society on April 5, 1968. Dr. Harvey recommended:

> **"That the Baltimore City Medical Society urges the State Health Department to take all neeessary steps to develop needed reporting forms and programs to permit analysis of physician serviees in the State Medieaid Program, as soon as possible."**

This statement was approved by the Board of Directors and forwarded to the Commissioner of the State Health Department.

Philip F. Wagley, MD, Chairman of the Policy and Planning Committee submitted a letter designed to be distributed to the local medical schools, hospitals, colleges and junior colleges in the vicinity of Baltimore City, stating the position of the Baltimore City Medical Society regarding the training of paramedical personnel, offering support in forming training programs, and asking what is presently being done by these institutions in this vein. This letter was approved and will be circulated in the near future.

In conjunction with this, John N. Classen, MD, suggested that a proposal be made to the State Medical Society in support of the continuation of the three-year nursing school programs presently in operation, until such time as other adequate replacement programs are in active operation. The Board discussed the nursing school problem in detail and reiterated its concern over the growing need for more adequately trained bedside nurses.

The Board agreed to cooperate with the Community Chest-Red Cross United Appeal by sending a questionnaire to all physicians in Baltimore City to learn how many are now contributing to the campaign and how these contributions are being made.

The Bylaws of the Baltimore City Medical Society are in the process of being reprinted and will be available during the next general meeting of the Society on October 4, 1968 or upon request to the Society office.

Since a large number of members of the Society have indicated that some night other than Friday, should be considered for general meetings, the Board decided to suggest that a pilot study be begun in the coming year to ascertain what night would be suitable to the majority of members. This will be discussed further at the general meeting in October.

The meeting was adjourned at 6:00 P.M.

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executive secretary's newsletter

July, 1968

INDISCRIMINATE PRESCRIBING OF METHADONE

The Chief Medical Officer of the Supreme Bench, Baltimore City, has cautioned physicians about the indiscriminate prescribing of Methadone.

By willingly prescribing this drug for addicts, the physicians contribute to illicit selling of this drug. Addicts have been obtaining Rxs from several physicians at the same time. Adequate histories are not obtained, frequently; nor have checks been made into the current history of addiction.

Methadone is an addictive narcotic drug and should only be used as replacement therapy for long term, chronic, addicts who have a drug habit that has existed for 3 or 4 years, and that has not responded to other less heroic forms of treatment.

Methadone should only be used under strict control and supervision. It should not be used for the young teenager or other addicts who have not had an opportunity to attempt any abstinence type of program.

Physicians are cautioned about what could represent poor medicine; and about difficulties in which they may find themselves if this drug is prescribed indiscriminately.

NEWS NOTES

Stuart H. Brager, M.D. has returned from military service and is now practicing Internal Medicine at 101 East Biddle St, Baltimore.

Howard D. Bronstein, M.D. is now associated in the practice of Gastroenterology with Charles I. Siegel, M.D at 11 East Chase St, Baltimore.

Elliott Michelson, M.D., and Robert J. Wilder, M.D. are now located at 200 West Cold Spring Lane,Baltimore.

John D. LeBouvier, M.D., has returned to his practice of Orthopedic Surgery at 715 Park Avenue, Baltimore.

Charles P. Crimy, M.D., Baltimore, was presented with a special award in connection with the Family Practice program at the University of Maryland Medical School. The event took place at the annual meeting of the Maryland Academy of General Practice in Annapolis.

Paul V. Lemkau, M.D., Baltimore, has been installed as Vice-President of the American Psychiatric Association.

Camp Glyndon for Diabetic Children has started the initial phase of a $500,000 building program in Glyndon. Wilson L. Grubb, M.D., is president of the Maryland Diabetes Association and Abraham A. Silver, M.D., is the medical director, sponsors of the Camp.

Louis Padovano, M.D., Woodstock, has returned to Viet Nam for an additional 90 day stint in the AMA Volunteer Physicians for Viet Nam program. Glendon E. Rayson, M.D. Baltimore, is also serving on an initial tour of duty.

THERAPEUTIC ABORTIONS

Guidelines for Hospital Staffs in Performance of Therapeutic Abortions have been adopted by the Council. Copies have been mailed to all Faculty members, as well as Chiefs of Staff at all Maryland General Hospitals. Individual copies are available through the Faculty office.

REFERENCE COMMITTEE MEETING

The Reference Committee of the Faculty meets on

THURSDAY, AUGUST 15, 1968 at 8:00 P.M.

in the Faculty Building. Resolutions up for consideration at the Faculty's Semiannual meeting will be discussed at that time.

Full details will be available after July 15, 1968, the deadline for the introduction of resolutions for consideration at the Semiannual meeting.

A CAUTIONARY NOTE

Considerable confusion is being created in the minds of both patients and third party insurers by physicians who indicate one charge to the patient, only to change this fee when notifying the carrier of the amount billed.

Physicians should make every endeavor to ensure that both patients and carriers are provided with accurate and complete information. Under the new Commission on Medical Discipline such action, if proved to be dishonest or unethical, can be cause for disciplinary procedures.

John W. Sargeant
Executive Secretary

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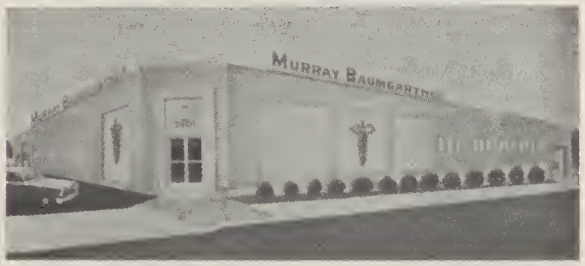
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PHYSICAL STANDARDS IN WORLD WAR II by Colonel Robert S. Anderson, MC, USA; Office of the Surgeon General, Washington, D.C. 1967.

This book is devoted to the many varying standards used during World War II in inducting men and women into the armed services. While full of statistical charts and other information that must be studied at length to understand them, it has many interesting and revealing other areas of information. The influence of physical stamina and mental attitude upon military efficiency is, in a prologue, traced from Biblical times to current days. This alone makes for interesting reading.

THE COUNTRY DOCTOR AND THE SPECIALIST by Fred Lyman Adair, MD; Adair Award Fund, Maitland, Fla. 1968.

This book is devoted to the history of the lives of father and son physicians. In this autobiography, Fred Lyman Adair, MD, relates incidents in the life of the father, a general practitioner in a town in Iowa; and incidents in his own life as an Obstetrician and Gynecologist. It is interesting, and sometimes, amusing reading.

PEDIATRIC THERAPY, THIRD EDITION, 1968-69, by Harry C. Shirkey, MD, The C. V. Mosby Company, St. Louis, Mo. 1968.

The emphasis in this book is on therapy. However, precise diagnosis is stressed throughout and

is further supported by photographs that relate the treatment less to pages and more to people.

Cross references direct the reader to related subjects without requiring frequent use of the index. The number of subjects and contributors has increased by adding the contributions of those who have distinguished themselves in their areas of competence. And the Table of Drugs has been enlarged, thereby preventing the needless repetition in each chapter of drugs in their individual dosage and preparation. This helps to reduce the length of each chapter and the total book.

It is one well worth adding to your library of valuable reference editions.

MEDICAL PHYSIOLOGY, Volumes 1 and 2, by Vernon Mountcastle, MD; The C. V. Mosby Company, St. Louis, Mo. 1968.

This 12th edition of Medical Physiology presents a cross section of knowledge of the physiologic sciences, as viewed by a group of 31 individuals, 23 of whom are actively engaged in physiologic research and teaching.

The main purpose of this series of books is "to present that part of physiology which is of special concern to the medical student, the practitioner of medicine, and the medical scientist in terms of the experimental inquiries that have led to our present state of knowledge."

The scope of this edition is broader than previous ones, however, and attempts to present mammalian physiology as an independent biologic discipline as well as a basic medical science.

Of the 80 chapters comprising this book, 29 are wholly new in this edition; 45 from the last edition have been extensively revised; and six have been allowed to stand substantially as previously published.

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9:00 a.m. — 4:00 p.m.
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Ramsay B. Thomas, MD, Chairman of Arrangements

9:00 AM — REGISTRATION — COFFEE

10:00 AM — OPENING REMARKS

President of Catonsville Community College

Arthur G. Siwinski, MD, President
Medical and Chirurgical Faculty of the
State of Maryland

10:20 AM — Room A — "YOUNG WOMEN IN SPORTS: MYTHS AND TABOOS"
Room B — "MEDICAL ASPECTS OF WEIGHT CONTROL IN ATHLETICS"

11:00 AM — INTERMISSION — VISIT EXHIBITS

11:15 AM — Room A — "PREPARATION OF THE ATHLETE FOR COMPETITION: PRE-SEASON CONDITIONING: MAINTAINING PHYSICAL FITNESS DURING SEASON COMPETITION"
Room B — "MEASUREMENT OF PHYSICAL FITNESS"

NOON — LUNCHEON

1:15 PM — Room A — "INJURIES TO THE SHOULDER GIRDLE"
Room B — "SKIN PROBLEMS IN ATHLETES"

2:00 PM — Room A — "INJURIES TO THE FACE"
Room B — "THE MEDICAL ASPECTS OF THE OBESE CHILD IN ATHLETICS"

2:45 PM — INTERMISSION — VISIT EXHIBITS

3:00 PM — Room A — TAPING CLINIC
Room B — TAPING CLINIC
Room C — TAPING CLINIC
Room D — TAPING CLINIC

3:45 PM — CLOSING REMARKS
DISTRIBUTION OF CERTIFICATES

4:00 PM — ADJOURNMENT

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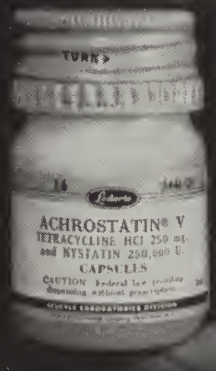
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Baltimore County Medical Association

The May meeting of the Baltimore County Medical Association was held at Meushaw's Restaurant in Woodlawn on the 15th. Following the luncheon, the meeting was called to order by Sidney J. Venable, Jr., MD, President.

Dr. Venable greeted and welcomed Robert Fisher, MD, a new member. The minutes of the previous meeting were approved; and Wilmer Gallager, Jr., MD, read the Treasurer's report.

COMMUNICATIONS: A letter from William Pillsbury, MD, Secretary of the Medical and Chirurgical Faculty informed the association that its resolution, proposed at Annual Meeting, had been approved.

LEGISLATION: J. Morris Reese, MD, Chairman of the Legislative Committee, reported the Medical Discipline Act has been signed by the Governor, the Abortion Act had been signed and the Generic Drug Bill had been vetoed. Donald J. Roop, MD, stated another bill was passed concerning the control of alcoholism. This was part of the Mental Health Bill and is the only section which passed. However, there has been no provision for financing a program for alcoholics.

In addition to this information, Dr. Roop stated that administrators of all General Hospitals in Baltimore County have been approached regarding establishing alcoholism units and he is hoping that something will be worked out in the near future.

MEDICAL-CHIRURGICAL ANNUAL MEETING: Samuel Bacon, Jr., MD, reported on the Annual Meeting and stated the most discussion centered around Resolution 6–A which will be referred to the Reference Committee for further study prior to the Semi-Annual meeting in Ocean City when it will be proposed for enactment.

NEW BUSINESS: Applications for membership from Remsi Dimir, MD, and Benigno Oteyza, MD, were approved.

SCIENTIFIC MEETING: Theodore C. Patterson, MD, introduced Matthew DeBuskey, MD, associate professor of pediatrics at The Johns Hopkins School of Medicine, who spoke on "The Doctor and the Adolescent." Dr. DeBuskey presented a study of 153 cases and elucidated the reasons for admitting adolescents to The Johns Hopkins Hospital.

Dr. Venable thanked Dr. DeBuskey, and the meeting was adjourned.

SAMUEL N. BACON, JR., MD
Chairman, Public Relations

Medical Assistants' Week Celebrated In April

Annual Medical Assistants' Week was celebrated from April 14 through April 20, 1968. The events of the week included participation at the Health Evaluation Center and coffee booth at the Alcazar during the Annual Meeting of the Medical and Chirurgical Faculty of Maryland, April 17–19; and the presentation of a Variety Show at Loch Raven Elementary School on April 19 for the benefit of the MAMA Scholarship Fund.

The show's committee members generously donated their time to organize the following program: Charles Weber, vice president of Jody Enterprises Recording Studio, was Master of Ceremonies; Ruth Jones, Mary Ellen Barnes, Carol Townsley and Janet Phillips from the Dorothy Virgilio School of Dance, formed the chorus line; Shirley Coffman, Pat King, Jackie Grant and Jan Albert comprised the Sweet Adelines Barbershop Quartet; and Diana Shope from the Maryland Cabaret Theatre entertained. Also on the program were "The Grapes of Wrath" a British Rock 'n Roll group consisting of Tim Wells, Roland Moskil, Bud Messick, Tom Wilhelm, and Randy Jenkins; The Fantastiks Specialty Act was performed by John Lesnick, John Leber, Albert Maggitti and Jo Mackovec; and Dottie Robinson, Fran Zebrowski and Bernie DePasquale formed a Folk Singing Trio.

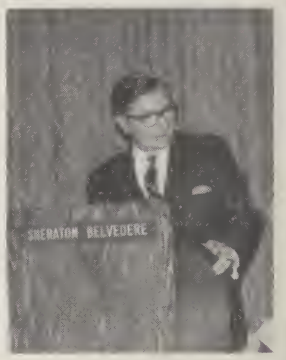


Milton B. Kress, MD, Assistant Professor of Medicine, The Johns Hopkins University, gave the welcoming address at the afternoon session of the Eighth Annual Meeting of MAMA.

The events of the week were climaxed with the Eighth Annual Meeting of the Maryland Association of Medical Assistants on Saturday, April 20, 1968, at the Sheraton-Belvedere Hotel. Registration was held at 10 AM, and the business meeting commenced at 10:30 AM. During the meeting, election of officers was held. **Gertrude Gillum** was elected President; **Barbara Daniel**—President-Elect; **Betty Porter**—Vice-president; **Anne Schultz**—Secretary; **Mabel Young**—Treasurer.

Delegates for the American Association of Medical Assistants Annual Convention were also elected. They are: **Nell Chaney, Dorothy Hartel, and Gertrude Gillum.**

The afternoon education session began at 1:30 PM, with the welcoming address by Milton B. Kress, MD. Mrs. Eleanor Nash, Columnist for the Sunpapers, was the first guest speaker. She spoke on "Public Relations." Ephraim Lisansky, MD, was the next speaker, and his topic was "Psychosomatic Medicine."



Master of Ceremonies for the celebration dinner was Ian R. Anderson, MD, Resident in Surgery, Church Home and Hospital.

The evening's festivities began with cocktails at 6 PM and the banquet commenced at 7 PM with the invocation by Rev. Thomas Subock. The Master of Ceremonies was Ian R. Anderson, MD.

An oriental theme prevailed for the evening, and the kimono attired hostesses were **Dolly Stuck, Rita Cobry, and Carol Davis.**

The Candlelight Ceremony followed dinner and the newly elected officers were installed.



"Psychosomatic Medicine" was the topic of a speech given by Ephraim Lisansky, MD, Associate Professor of Medicine and Psychiatry at the University of Maryland School of Medicine. Dr. Lisansky addressed the afternoon session.

Medical Assistants



Kimono attired hostesses helped set the scene for the Oriental celebration dinner given in April at the Sheraton-Belvedere. Hostesses pictured are Dolly Stuck (left) and Rita Cobry.



Installation of newly elected officers took place at a candlelight ceremony following the dinner.

Baltimore Association of Medical Assistants Celebrate Annual Bosses' Night

On Tuesday, May 14, 1968, at the Center Club, the Baltimore Association of Medical Assistants held the Annual Bosses' Night. The festivities started at 8 PM with cocktails followed by dinner.

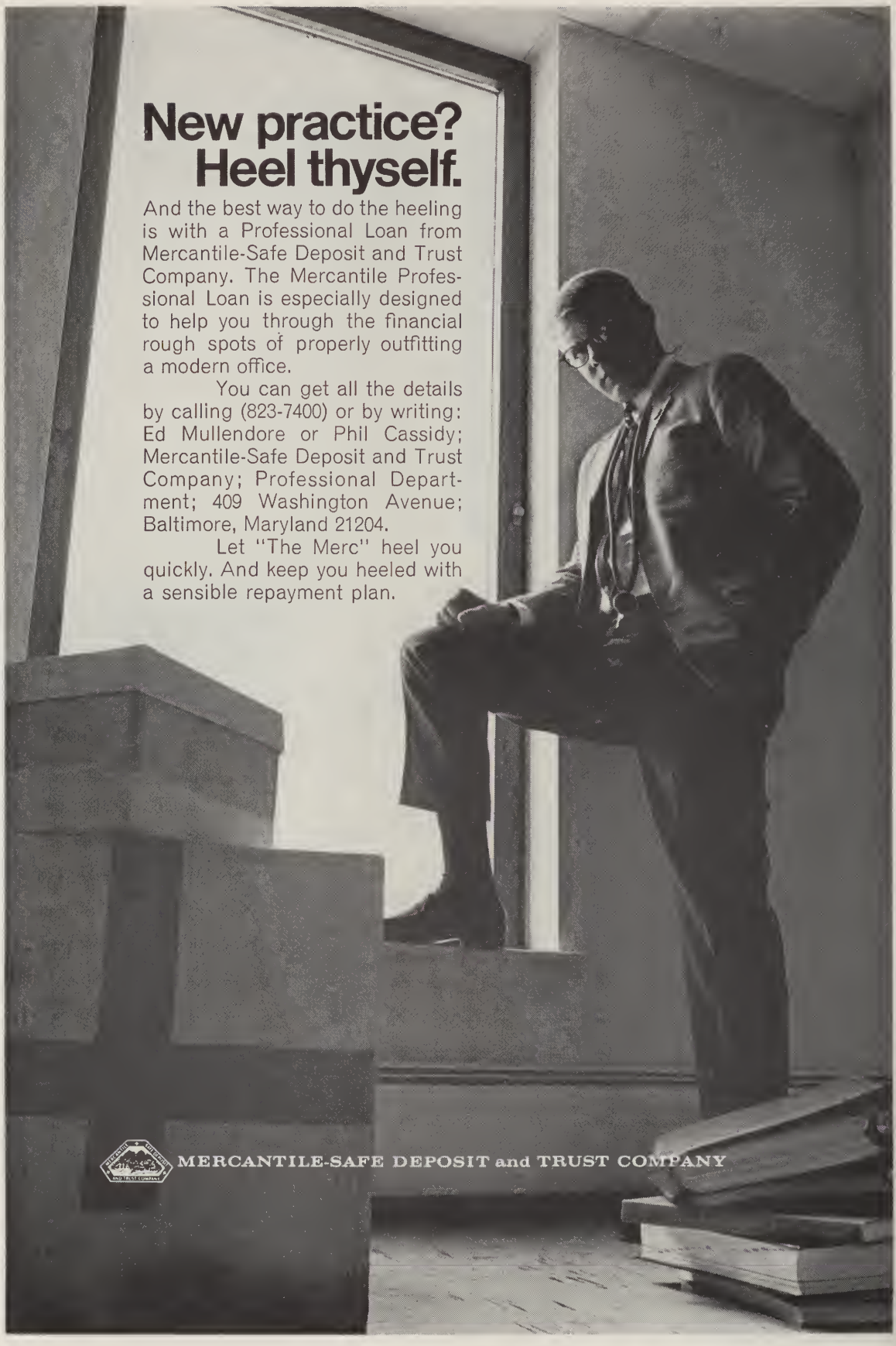
Following dinner, members of the association presented a skit entitled "Mountain Medicine." Participants in the presentation were **Barbara Daniel, Dorothy Hartel, Valerie Hachtel, Carmella Sartori, Elva Edmonston, and Peggy Bury.**

Certificates were presented to the members who completed the recent course in Anatomy and Physiology conducted by Raymond Atkins, MD.

Past State President of MAMA Makes Television Appearance

Nell Chaney, past president of the Maryland Association of Medical Assistants, appeared on WMAR-TV at 10 AM on June 9, 1968. Mrs. Chaney appeared with Mrs. Eleanor Nash of the Sunpapers, and they discussed the MAMA program. In their 15-minute discussion, Mrs. Chaney and Mrs. Nash familiarized the listeners with the educational activities of the Maryland Association of Medical Assistants, and also the jobs available through the association.

Mrs. Chaney's TV appearance was in conjunction with the association's aims to acquaint medical assistants with the many benefits of belonging to an organization like MAMA.


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Population May Explode Again Within Ten Years

The United States may soon be in the midst of another population explosion, the Health Insurance Institute said recently.

Current estimates are that the nation can expect a new baby boom within five to 10 years—possibly sooner.

The prediction is made despite last year's rate of 17.9 births per 1,000 population—the lowest annual rate on record. Total births in 1967 were 3,533,000, almost 100,000 fewer than the year before.

Predict New Highs

While some demographers use these figures to make a case against a population jump, others predict that the problems of a growing population are just ahead.

These experts say there will be record numbers of babies born in the 1970s, with a good chance that the population will double and reach 400 million persons by the end of the century.

The rise in marriages to 1,913,000 last year—the fifth successive year there was an increase—is one indicator.

Another is that a new crop of eligible husbands—young men between 21 and 24, in short supply since 1956, are now coming of age.

Disparity

For every 100 marriageable young women, the Institute estimates, there are only 91 marriageable young men.

By the 1970s, this disparity is expected to be corrected.

According to the Information Center on Population Problems, "there is good reason to anticipate a new—and perhaps bigger—baby boom at the end of the decade."

Peak Months Ahead

Some birth experts point out that despite the use of birth control pills, the size of families will not necessarily be reduced. The pills are used frequently, they say, only to allow couples to space their offspring more conveniently.

But however the baby population fluctuates, the HII says the traditional peak baby months of summer are expected to continue.

During July, August, and September of 1968, if past years are any indication, about one million babies will be born in the United States.

Who pays the bills?

The Institute notes that in 6 out of 10 cases, the total number of people covered by group protection have maternity benefits in policies that have been issued by private insurance companies.

Maternity coverage, says the Institute, is available on all family policies.

Parents-to-be would do well to check their health insurance on this point, the Institute said.

Hospital benefits may vary from $50 to $300, or over, with extra coverage if a delivery is complicated.

Insurance for a newborn baby depends on the particular policy. Some insure the baby from birth, while a few policies do not offer health protection until the baby is 15 days old, or is discharged from the hospital.

However, the current trend among insurance companies—especially where group policies are concerned—is to begin coverage as soon as possible.

Parents with group health insurance are advised by the Institute to notify their insurance company or employer as soon as their baby is born.

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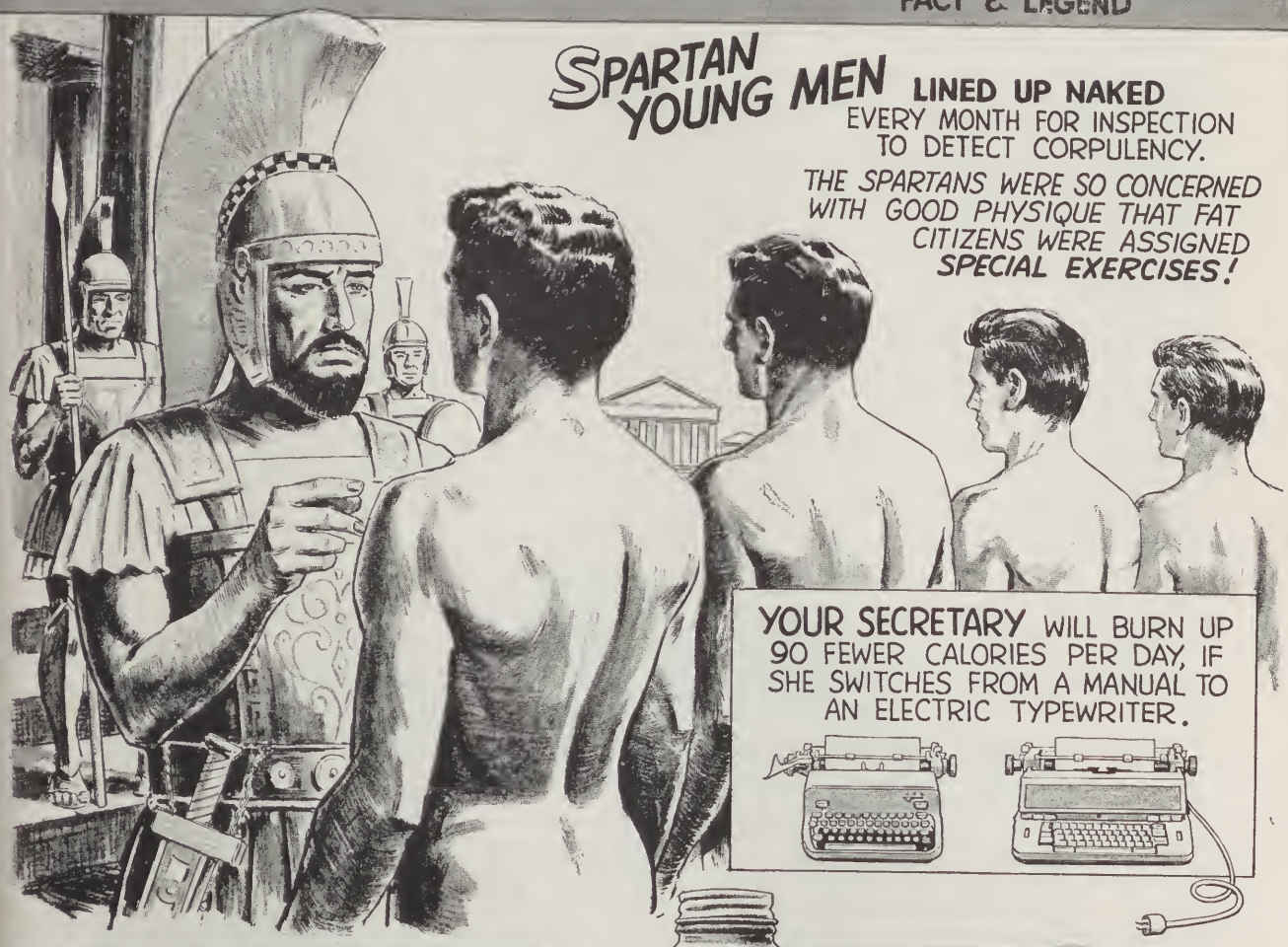
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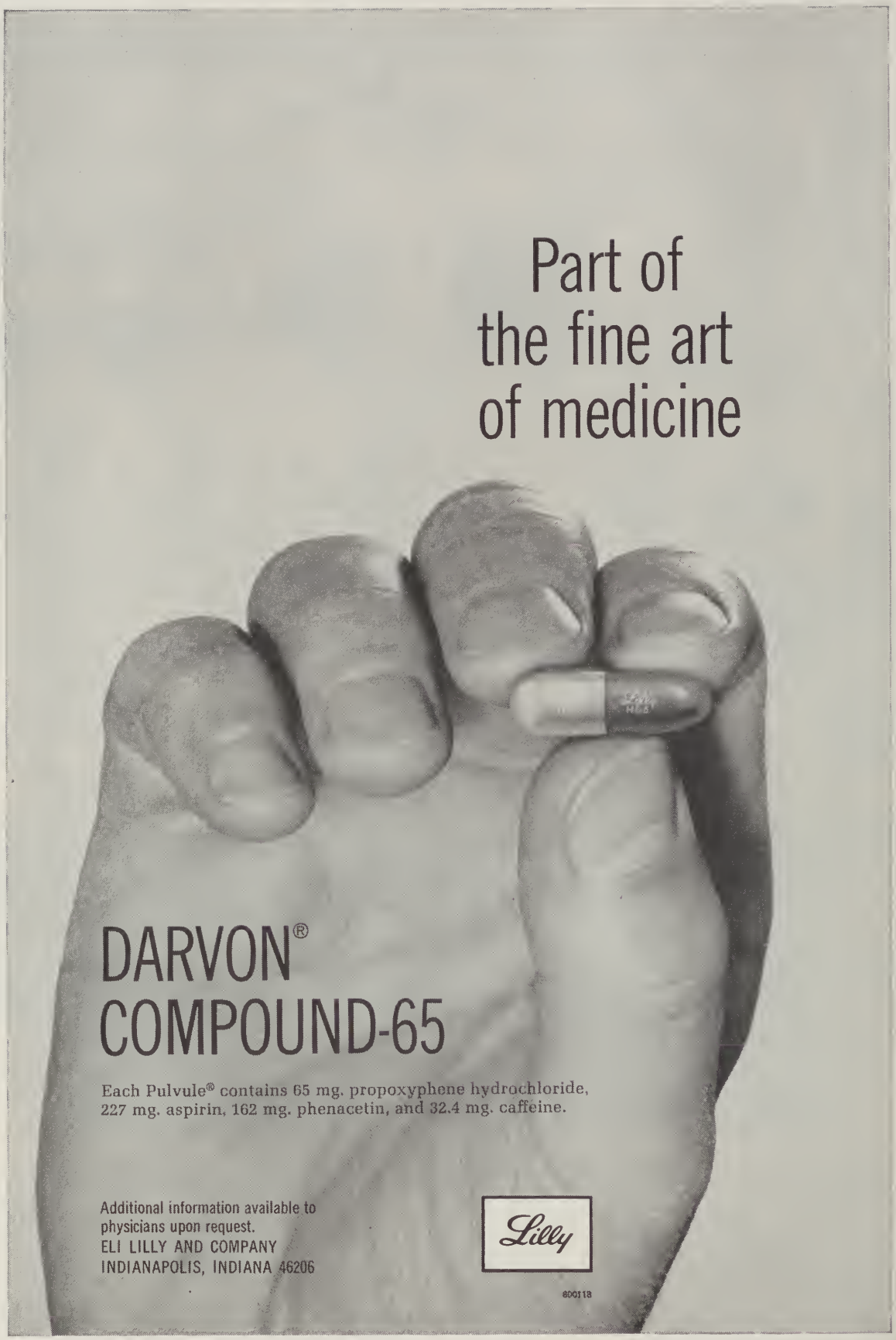
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Medicare Enrollment Now at 95%

The percentage of people 65 and over enrolled in the doctor bill insurance part of Medicare went up from 92 to 95% during the 6-month open enrollment period that ended April 1, Robert M. Ball, Commissioner of Social Security, announced recently.

About 700,000 older people who had missed out on their first chance to enroll for the medical insurance to supplement their basic hospital insurance under Medicare signed up between October 1, 1967, and April 1 of this year.

Ball said that 18.6 million of the 19.6 million persons 65 and over in the Nation are now enrolled for the voluntary medical insurance that helps pay doctors' and surgeons' bills and a variety of other health care services. About 17.9 million had the medical insurance protection at the beginning of the open enrollment period.

Commissioner Ball noted that participation in the doctor bill insurance rose from 92 to 95% despite an increase of $1 in the monthly premium paid by those enrolled. And only 36,000 older people gave notice of their wish to disenroll between October 1, 1967, and April 1, 1968.

The increase in the premium rate, from $3 to $4, effective with the month of April, and announced in December 1967, was necessary in part to finance the improved medical insurance coverage and in part to cover higher than estimated current and projected costs of the program.

The $4 monthly premium paid by older people who sign up for the medical insurance represents half the cost of the protection. The Government pays the other half of the cost.

The next open enrollment period will begin next January, Ball said, and will end March 31, 1969, with coverage beginning July 1, 1969. In the meantime, he advised those approaching 65 to sign up for the supplementary doctor bill insurance during the 3 months before the month of their birthdays so that their protection can begin as soon as they are 65.

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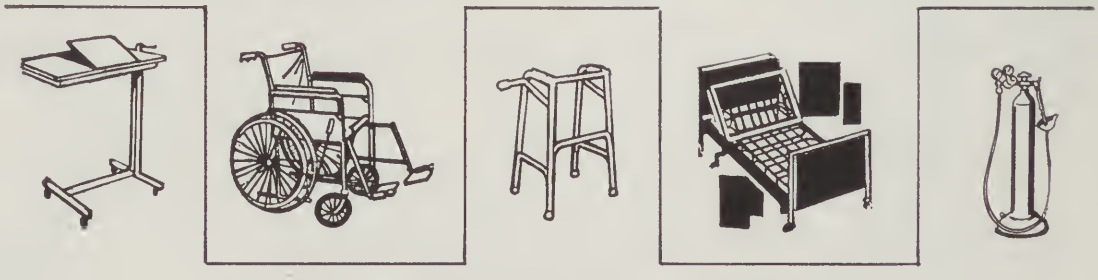
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'67 Highway Death Toll Less than in '66

In 1962 highway deaths topped the 40,000 mark. Three years later the figure was 48,500 and in 1966 America's highways were stained with the blood of 52,500 persons.

The skyrocketing figures paused—even dropped a bit—in 1967. The year-end toll stood at 52,200, according to the highway accident booklet released annually by The Travelers Insurance Companies.

Tragedy did not stop with the deaths, but added 3,840,000 persons to the *1962* injured list. 4,400,000 were injured in *1966* and 4,200,000 in *1967*—a reduction of some 200,000.

"The record of 1967 gives us the first appreciable improvement in this respect that has taken place in more than a decade," according to an insurance spokesman. "The satisfaction this gives must be qualified, however, for it will require many more years of consistent betterment before we can claim any genuine progress toward the conquest of a stubborn and tragic problem," he added.

Adverse weather was not an important contributing factor in 1962 or 1967. Records show that last year some 80% of the fatal crashes occurred on clear days and dry roads. The remaining 20% occurred in fog, rain and snowy weather.

Excessive speed continues to hold top spot in the list of accident causes, with reckless driving and driving on the wrong side of the road taking second and third places respectively. Pedestrians were at fault in many of the fatal accidents, with crossing between intersections being the top killer.

Youthful drivers hold the greatest responsibility on the highway death list. Almost one third of the drivers involved in fatal accidents were under 25 years of age.

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"Guides to the Evaluation of Permanent Impairment — The Reproductive and Urinary Systems"

This guide, like all the others in the series of 11 developed by the AMA Committee on Rating of Mental and Physical Impairment, has been designed primarily for use by physicians. However, it is of interest and use to all concerned with the medical, administrative or judicial aspects of programs for the disabled.

The previously published guides deal with the extremities and back; the visual system; the cardiovascular system; ear, nose, throat and related structure; the central nervous system; the digestive system; the peripheral spinal nerves; the respiratory system; the endocrine system; and mental illness.

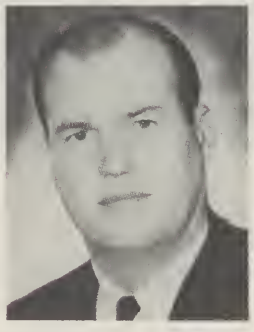
A limited number of these guides may be obtained, without charge, upon written request to the Committee on Rating of Mental and Physical Impairment, 535 N. Dearborn St., Chicago, Illinois 60610.



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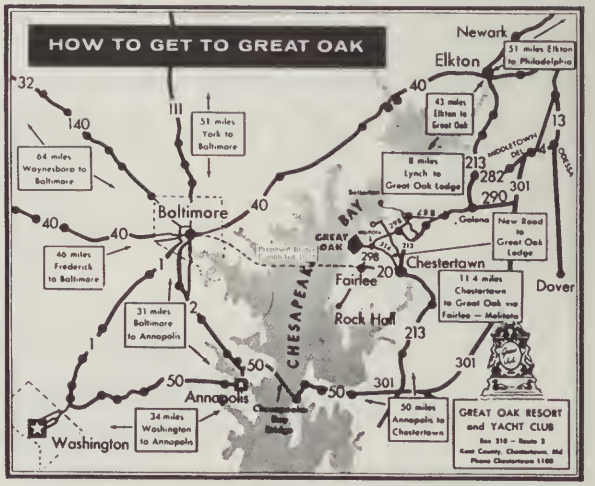
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AMPAC Fellowship Established

The American Medical Political Action Committee, AMPAC, has established a Fellowship in Business-Government Relations at The American University's School of Business Administration.

AMPAC will provide annually a Graduate Fellowship of $4500, plus a $500 grant to the Business-Government Relations Program. AMPAC now joins Whirlpool which presently offers two similar Fellowships. Other contributors to this growing Program are The American Oil Foundation, Corning Glass Works Foundation, The General Electric Foundation, Hill & Knowlton, Inc., Hughes Aircraft Company, PPG Industries Foundation, Sears, Roebuck and Company, and Standard Oil (Indiana) Foundation, Inc.



Dr. Blair Henningsgaard, Chairman, American Medi-l Political Action Committee, presents a check for 5,000 to Robert W. Miller, Director of the Business-overnment Relations Program at The American Uni-ersity's School of Business Administration, for the rst AMPAC-Business-Government Relations Gradu-e Fellowship.

In making the grant, Blair J. Henningsgaard, MD, the Committee Chairman, said, "The decision of the AMPAC Board of Directors to establish a Fellowship at The American University was based upon our conviction that the relationship existing between government on the one hand, and business and the professions on the other, are becoming more complex each year.

"The American University's Business-Government Relations Program, conducted by the School of Business Administration, is the only academic department of its kind in the country, and its pioneering effort in this vitally important field meets a long felt need."

In announcing the Fellowship, Professor Robert W. Miller, Director of the Business-Government Relations Program, said, "Important research by our graduate students is helping to develop more balanced literature and promotes a greater understanding of the nature and contribution of private enterprise to our total society. The students holding these Fellowships over the years will, through their research, make a valuable contribution to this literature.

"It is gratifying to know," he concluded, "that an organization like AMPAC has taken the initiative to look beyond its own profession in hopes of generating a useful interface with business, government and the professional community."

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New Mental Health

A revision in the National Institute of Mental Health's Small Grants program was announced recently by Stanley F. Yolles, MD, Institute Director.

Under the new program, mental health small grants may be requested for a year or less, in amounts up to $5000 for the direct costs of conducting the research, plus the appropriate indirect costs. (Indirect costs include overhead and administration of the grants, and are awarded to the institution where the research is being done.)

The Small Grants Program provides financial support for a year or less in a relatively flexible manner for studies in behavioral, biological and medical sciences relevant to mental health. Such grants are of particular value to investigators who do not have resources available from their institutions for support of preliminary research explorations.

Small grants may be used to develop and test

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a new technique or method; to exploit an unexpected research opportunity; to analyze data previously collected; or to carry out exploratory or pilot studies. If such explorations open the way for more extensive research, the investigator can apply for a regular research grant.

The same Public Health Service regulations and policies apply to both research project grants and mental health small grants.

Applications will be processed as they are received and will be assigned for review to the next scheduled meeting of the Mental Health Small Grant Committee which meets six times a year. Approximately three months should be allowed from the time of submission of the application to the desired starting date of the grant.

For additional information and application forms write to: Chief, Small Grants Section, National Institute of Mental Health, 5454 Wisconsin Ave., Chevy Chase, Md 20203.

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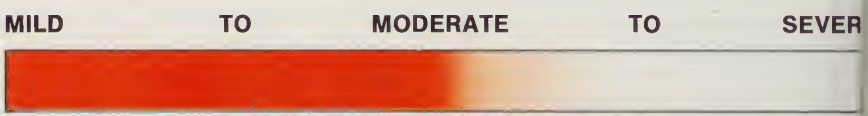
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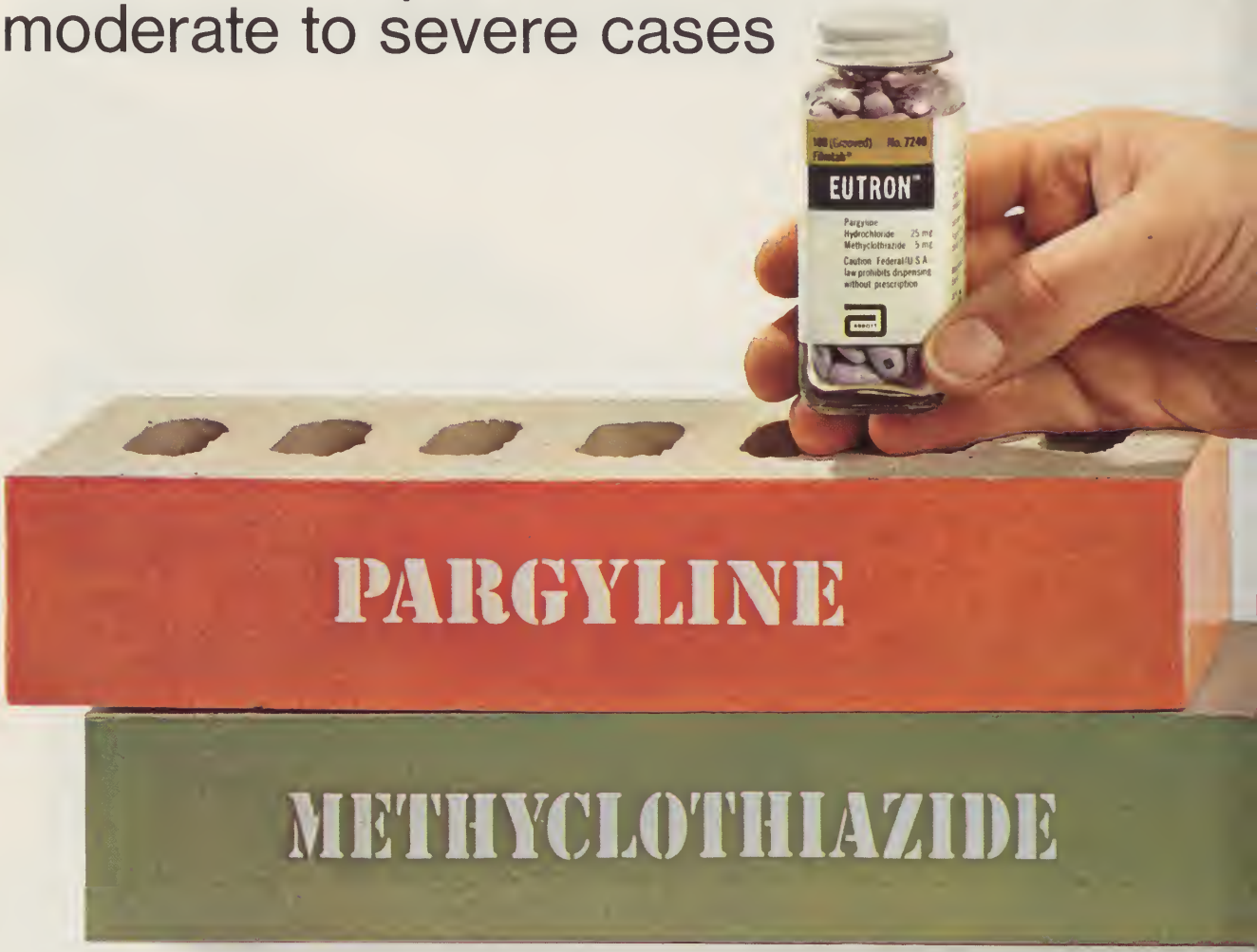
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MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

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Each tablet contains Methyclothiazide 5 mg. with Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains Pargyline Hydrochloride 25 mg. with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage; caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

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The Council on Legislative Activities:

It Analyzes Proposed Medical Legislation

Keeping track of whatever pops into the Capitol Hill legislative hopper that can have any direct or indirect bearing on the medical profession or public health long has been an obligation carried out by the American Medical Association on behalf of the medical profession.

Through the years this task has been performed by the AMA's Council on Legislative Activities, 13 perspicacious physicians appointed by the Board of Trustees, and its predecessors—the Bureau of Legal Medicine and Legislation and, prior to 1924, the Council on Health and Public Instruction.

But never has the task been so formidable as it is today. Under the "Great Society," a once-steady stream of 300-or-so bills has swelled into a torrent of proposed legislation that has severely challenged the energies of the Council members and their nine-member AMA staff, which includes three attorneys, one a legislative attorney permanently assigned to the Washington Office.

Almost overnight health care has been catapulted into a position of paramount national concern. The successes of American medicine have led to an increasing demand, and there has been a pervasive search for ways to obtain more health care services through legislation.

The legislative statistics clearly speak for themselves. During the 88th Congress (1963-1964), for example, the Council and its staff analyzed 860 bills of medical interest. Before the 89th Congress adjourned in 1966, that record activity on health legislation was paltry in comparison. In that session attention was focused on 1,526 bills. And in the first session of the 90th Congress (1967) another 1,127 bills had gone into the hopper.

This surge of legislative activity is reason enough to again focus attention upon the roles carried out by the Council in the interests of organized medicine. Since laws are drafted by legislators and others who seldom are experts in the areas their bills seek to cover, it is imperative that the proposals be weighed and judged by those whom they would directly affect—in this case, physicians and their patients.

As representatives of the medical profession, members of the Council and their staff have the responsibility of scrutinizing each bill of medical interest, striving to determine its strengths, its weaknesses, its immediate and long-range effects, its ramifications and subtle implications, if any.

After obtaining the expert views of many interested parties, the Council makes recommendations to the Board and these, sometimes, compel the need for policy-making decisions on matters of significant import.

Matters of the greatest interest to the profession occur in broad areas affecting medical education, medical practice, construction of health or teaching facilities and provision of medical services.

To effectively present the case for or against proposed legislation expert physician and non-physician witnesses are summoned to present AMA testimony before Congressional committees and sub-committees. During the first session of the 90th Congress, the Council developed 16 statements concerned with 11 legislative proposals. Of these 11 legislative issues, the Association favored six, opposed two and voiced partial support or opposition—or suggested an alternative approach —to the remaining three.

Even after laws are passed, the Council continues to seek modifications which it deems to be in the best interest of the public and the profession.

The "Medicare" law is a good case in point. Council efforts resulted in such beneficial amendments as payment on the basis of a physician's itemized bill rather than a receipted bill; transferring outpatient hospital diagnostic service to Part B of Title XVIII and expansion of its coverage; elimination of the previous requirement for initial physician certification for hospitalization of Medicare patients; and, under Title XIX, free choice of physician and facility, and the option for direct billing.

As a means of keeping medical societies and physicians thoroughly informed about the progress of national medical legislation, the Council distributes four principal publications. They are the *Legislative Roundup,* a brief summary and status report of pending medical legislation produced weekly when Congress is in session; *Medical Legislative Digest,* a publication produced on a varying schedule when Congress is in session; *Status of Medical Legislation,* published at the end of each session of Congress and providing essential information on all medical legislation considered; and *Federal Medical-Health Appropriations,* a detailed report prepared for each fiscal year.

The latter, incidentally, reveals that health care appropriations made by the Congress for fiscal year 1968 (ending June 30, 1968) amounted to $14.2 billion. This is an increase of almost 450% in the annual Federal appropriation for health, compared with fiscal 1960, at which time the appropriation was $3.2 billion.

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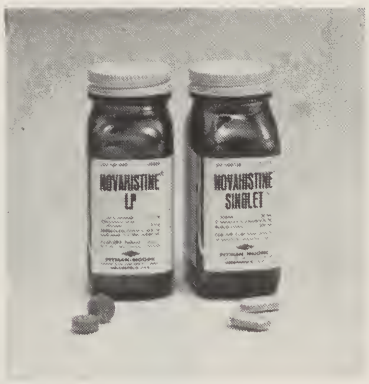
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Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindications: Known hypersensitivity to drug; children under 6 months of age; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in treatment of psychotic patients, and should not be employed in lieu of appropriate treatment. As with most CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may also be associated with temporary increase in frequency and/or severity of seizures. Advise patients against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance. Keep addiction-prone individuals (such as drug addicts or alcoholics) under careful surveillance because of their predisposition to habituation and dependence. Use of any drug in pregnancy, lactation or in women of childbearing age requires that potential benefit be weighed against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants. Employ usual precautions in the severely depressed or in those with latent depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

Adverse Reactions: Side effects most commonly reported: drowsiness, fatigue and ataxia. Infrequently encountered: confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo and blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, use of the drug should be discontinued. Because of isolated reports of neutropenia and jaundice, periodic blood counts and liver function tests are advisable during long-term therapy. Minor changes in EEG patterns (low-voltage fast activity) observed during and after therapy and are of no known significance.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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THE MONTH IN WASHINGTON

The American College of Radiology, defending the current use of X-rays by physicians, criticized published "scare stories" for causing unwarranted fears of X-ray examinations.

Richard H. Chamberlain, MD, a spokesman for the college, said such articles as one in a recent issue of the *Ladies Home Journal* distorted the facts in such a manner that it added up to "one of the most tragic things in medicine" by scaring people as to the possible effects of being X-rayed. Dr. Chamberlain said usage of X-rays by physicians in this country is "remarkably good."

"The risks to patients in the performance for medical X-ray examinations are vanishingly small," he said. "Diagnostic X-ray examinations do not endanger the health of patients, despite a few shrill claims to the contrary. We could cite millions of instances where X-ray examinations provide lifesaving information to patients."

The College supported in testimony before the Senate Commerce Committee a radiation standards bill, proposed after reports of radiation leaks from color television sets.

"The public has the right to expect protection against harmful amounts of inadvertent exposure to radiation from the operation of electronic devices," Dr. Chamberlain said.

He added that much more is known today about the effects of radiation than about many other environmental contaminants. Although more needs to be learned about the effects of low levels of radiation, he said, "we do know with assurance that their potential for harm is very small.

"The real tragedy occurs when even a single person may be misled by a distortion of radiation hazards to refuse a needed diagnostic X-ray examination," he said.

* * * * * * * * *

The Food and Drug Administration (FDA) has proposed new regulations for the classification of drugs found both safe and effective for their labeled uses in a survey of more than 3,600 prescription drugs.

The new procedures would open the way to increased competition within the drug industry by allowing firms to market drugs reclassified as "not new" or "no longer new" without submitting and awaiting approval of new drug applications (NDA) by the FDA.

A manufacturer that gets an NDA approval for a product has the right to market it exclusively. It is in effect an individual company license. Under the terms of the Food, Drug and Cosmetic Act, any medicine can remain in this "new drug" category regardless of how long it has been on the market.

The new proposal would set up a system for reclassifying the pre-1962 "new drugs" recognized as effective in the drug efficiency study being conducted for FDA by the National Academy of Sciences-National Research Council. The review, authorized by Congress in 1962, covers 3,690 drugs—every drug marketed in this country between 1938 and 1962. The drugs under review had been approved as "new drugs" solely on the basis of safety.

The FDA announced that two drugs—*metyrapone* and *metyrapone ditartrate*—would be the first "new drugs" reclassified under the proposal. Both were found effective for their recommended uses of testing the functioning of the pituitary glands. They are manufactured by CIBA Pharmaceutical Co.

In its second report to carry out recommendations of the study of every drug manufactured in the United States between 1938 and 1962, the FDA notified the manufacturer of a drug used in the treatment of severely painful menstruation to provide evidence within 60 days that the product is effective for conditions listed in its labeling. The drug *lutrexin,* manufactured by Hynson, Westcott & Dunning, Inc., of Baltimore, is available on prescription only.

The FDA also has issued a new warning about dangers of the antibiotic drug *chloramphenicol.*

* * * * * * * * *

Health, Education and Welfare Secretary Wilbur Cohen estimated that the medicaid program

may cost the federal government between $2.5 and $3 billion in the fiscal year 1971.

The estimate for the next fiscal year (1968) is $2.1 billion. The original estimate for the current year was $1.7 but that proved substantially low and the administration has asked for $500 million more.

Congress has put some restrictions on the medicaid program, effective this July 1, and they may result in holding down the 1971 costs below Cohen's estimate.

The Social Security Administration reported that the medicare Part B program, physicians' services, operated at a small deficit in fiscal 1967 which will be covered by the increases from $3 to $4 in monthly premiums.

The percentage of people 65 and over enrolled in the doctor bill insurance part of medicare went up from 92 to 95% during the 6-month open enrollment period that ended April 1. About 700,000 older people who had missed out on their first chance to enroll signed up between October 1, 1967, and April 1 of this year. Now, 18.6 million of the 19.6 million persons 65 and over in the nation are now enrolled for medicare voluntary medical insurance.

Social Security Commissioner Robert M. Ball said that the overall social security fund is in good fiscal condition. Medicare received $3.1 billion in fiscal 1967 and disbursed $2.6 billion, Ball said. He said estimates for the next 25 years showed that the program "has a favorable actuarial balance—namely, that total income over the 25 years ahead is expected to exceed total outgo."

Cohen told a House appropriations subcommittee that HEW was very much concerned and was making an intensive investigation of reported abuses by some physicians in federal medical programs.

He said a number of allegations had been made but that he would not want to make an overall statement until the investigation was completed.

"A typical kind of allegation concerns a doctor who goes into a nursing home—I will be just hypothetical about this—and he is there for an hour and then sends in a bill for an injection of something for every one of 50 people in the institution," Cohen said.

"Then we have had cases of bills being submitted in which the evidence suggests that the volume of services that he is requesting to be paid for is beyond the ability of a particular person to handle. Well, he comes back to that allegation and says, 'I have a nurse and I have an assistant' and so on. So we have to look into each one of them on their merits. We are doing that now.

"The popular criticism usually has to do with the individual fee. I really don't think that is the major issue. The real issue is not so much the fee or the price per unit, but the number of units that the person is saying he delivered."

Cohen said he did not think such practices are widespread but that:

"We have enough to be very much concerned about it."

* * * * * * * * *

A preliminary injunction was issued to halt the sale of a diathermy device distributed by the Diapulse Corporation of America.

The U. S. District Court for the Eastern District of New York, enjoined sales of the Diapulse device, advertised for treatment of 49 diseases and conditions, including tuberculosis, typhoid fever, staph infections, and gangrene.

The diapulse device was seized by FDA in 1965, and found to be misbranded on March 17, 1967, by a Federal court in Hartford, Conn., but the sale of the machine continued pending further appeals.

* * * * * * * * *

A group of physicians specializing in child health has endorsed a bill to require special safety containers for drugs, soaps and other household products involved in the poisoning of 500,000 children each year.

The Accidental Poisoning Committee of the American Academy of Pediatrics endorsed the measure sponsored by Chairman Warren G. Magnuson, D-Wash., of the Senate Commerce Committee. The Academy, in a letter to Magnuson, said the bill was the only "practical way to eliminate hazards from drugs and household products."

The government announced a ban on interstate shipment of household products containing carbon tetrachloride—a substance used in some cleaning fluids.

The Food and Drug Administration said use of the chemical in a home constitutes a hazard to public health and added there are many safer substitutes available. According to the FDA, carbon tetrachloride can be fatal if the fumes are inhaled. The chemical can also cause damage to the liver, kidneys, brain and nervous system, the agency said.

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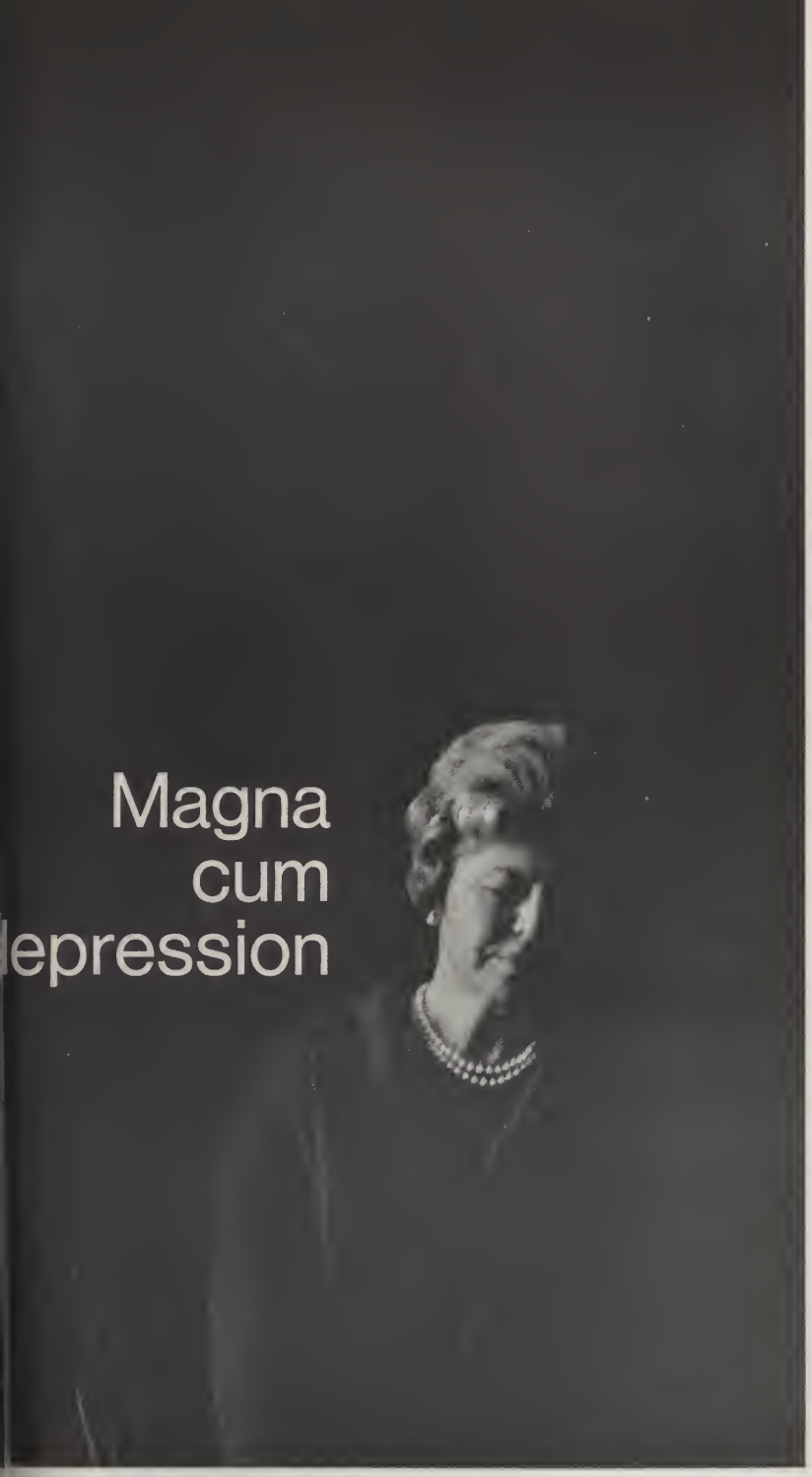
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Contraindications: The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be substituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, it should not be used during the first trimester of pregnancy. Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy. Because of its anticholinergic effect, caution should be observed in prescribing the drug for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients ceiving thyroid medication whe this compound was added to th regimen.
Imipramine may block the pharm cologic activity of guanethidine other related adrenergic neuron blocking agents.
The drug is not recommended at present time in patients under 1 of age.
Adverse Reactions: Dryness of e mouth, tachycardia, constipatio turbances of accommodation, s ing, dizziness, weight gain, urin frequency or retention, nausea vomiting, peripheral neuritis, m parkinson-like syndrome, trem rare cases of falling in elderly p tients, confusional states (with c symptoms as hallucinations and d orientation), activation of psyc schizophrenics and agitation (e ing hypomanic and manic episo which may require dosage red



For him, commencement.

For his mother, the beginning of his career may seem the end of hers. The end of feeling needed and useful. The beginning, perhaps, of a pathological depression.

Tofrānil can often relieve the symptoms of her depression. If it can relieve her mental anguish, you may be able to help her graduate into a new and fruitful life of her own.

Tofrānil could be her commencement, too.

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imipramine
hydrochloride

in depression

The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated.

In patients with cardiovascular disease, hyperthyroidism or increased intraocular pressure; in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication or adrenergic neuron-blocking antihypertensive agents; and in those in the first trimester of pregnancy, the precautions discussed in the Prescribing Information should be carefully observed. Although toxic reactions severe enough to require discontinuation of Tofrānil are uncommon, please refer to the Prescribing Information for a description of such instances when discontinuation may be necessary.

/or addition of a tranquilizer or porary discontinuation of the drug, eptiform seizures, orthostatic otension and substantial blood ssure fall in hypertensive patients, ɔura, transient jaundice, bone mar- depression including agranulocy- s, sensitization and skin rash uding photosensitization, eosino- ia, and mild withdrawal symptoms udden discontinuation after pro- ied treatment with high doses. asional hormonal effects (im- ence, decreased libido, and estro- c effects) may be observed. pine-like effects may be more ounced (e.g. paralytic ileus) in eptible patients and in those g anticholinergic agents (includ- antiparkinsonism drugs). *atient Adult Dosage:* Initially, ng. daily, increased, if necessary, 50 or 200 mg. Maintenance dosage be lower, 50 to 150 mg. daily, if sible.

Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily. A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)R-46-850-C

For complete details, please refer to the full Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

JANUARY	FEBRUARY	MARCH	APRIL
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MAY	JUNE	JULY	AUGUST
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Guidelines for Patients

Can your patients recognize a real emergency? Or is, as they see it, every bump or bruise, ache or pain an emergency?

The AMA's new pamphlet, "When To Call or See Your Physician," establishes guidelines helpful to patients determining when to seek medical aid.

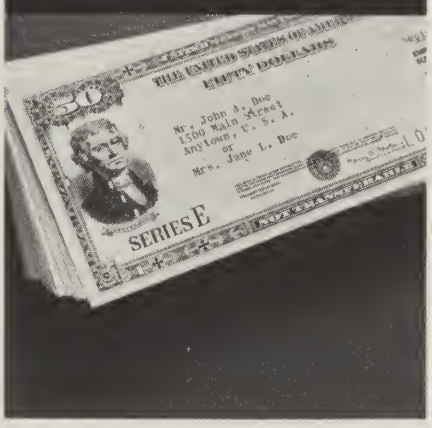
The pamphlet lists four indications which call for immediate medical attention—severity, persistence, repetition and doubt. Any one of the four is sufficient; two or more increase the urgency.

In addition, the pamphlet cites circumstances which indicate that a doctor's help is needed. Some of the common conditions described are blackouts, breathlessness, dizziness, fatigue, headaches, indigestion, itching, sores and swelling.

Single review copies may be obtained from the AMA's Health Education Department. Quantity orders are available from the Order Department at 15¢ each; 12¢ each for 100–499; 10¢ each for 500–999; 8¢ each for 1000 or more.



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When you stack one U.S. Savings Bond on top of another, it becomes a habit that's tough to break and hard to beat. That's because it's so painless. Just tell your employer or banker to set aside a regular amount for you before you have a chance to spend it. Sign up today.

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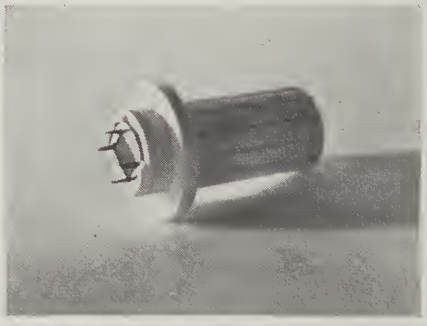
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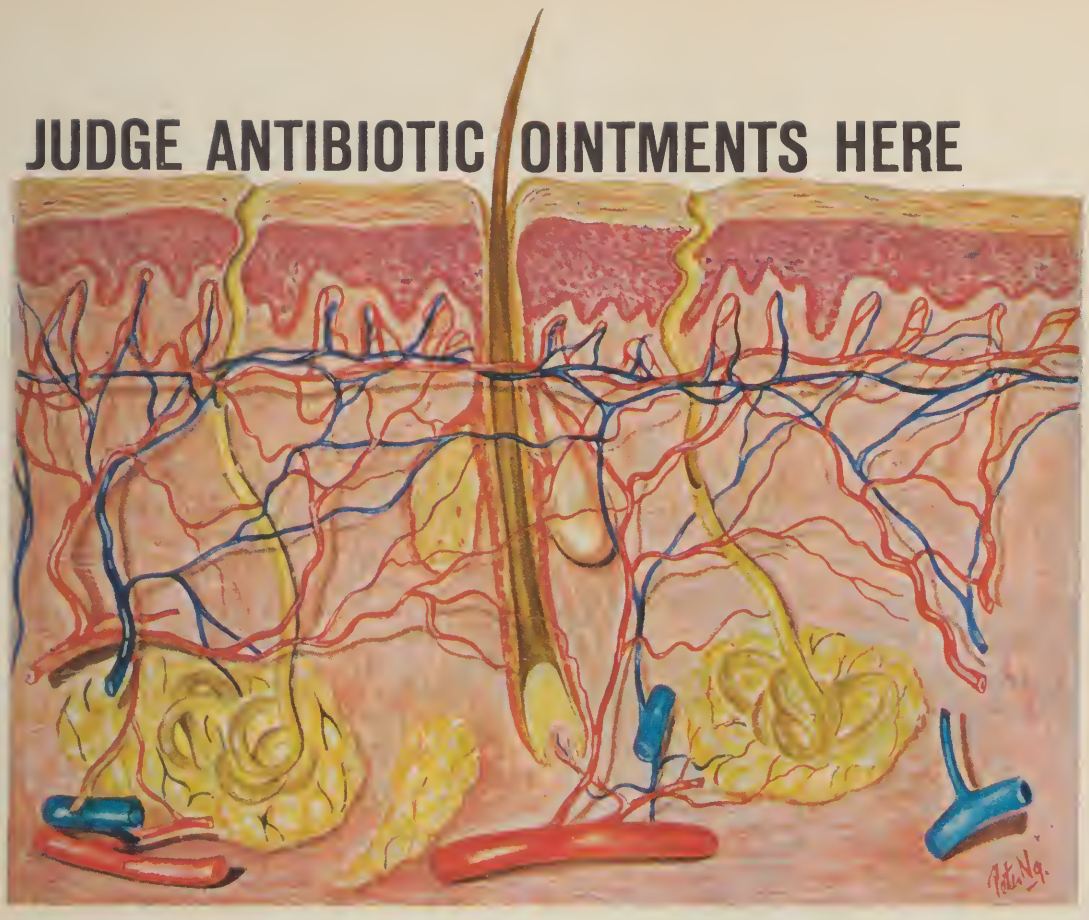
TUBERCULIN,TINE TEST (Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

Lederle

330–8/6135

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Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

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POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

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New

Therapeutic breakthrough in non-narcotic control of the pain of

Tegretol®
carbamazepine

trigeminal neuralgia

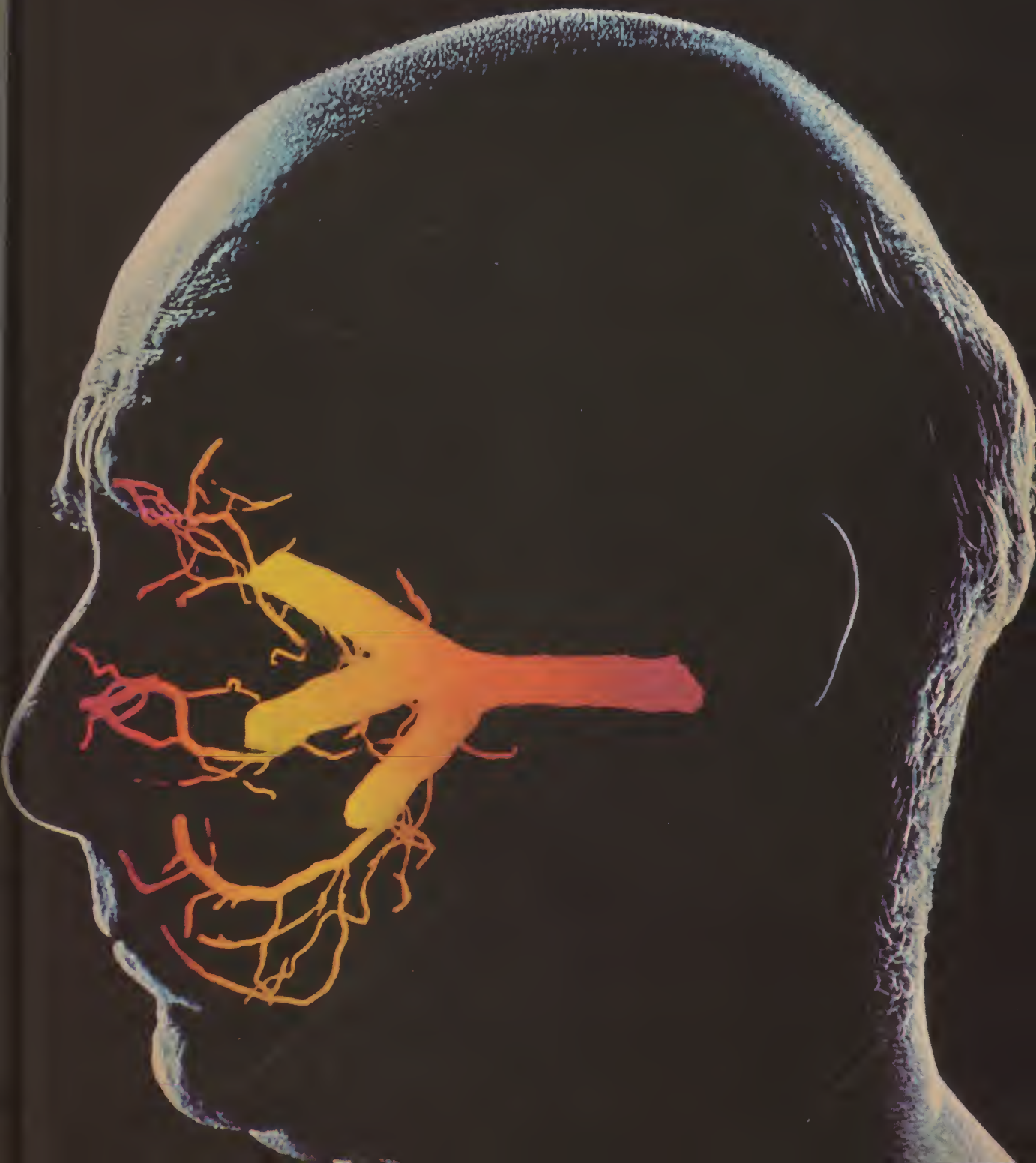
Warning
Fatal cases of aplastic anemia have been reported following treatment with Tegretol. Agranulocytosis, thrombocytopenia and transitory leukopenia have also been observed.
Complete blood and platelet counts should be done prior to and at regular intervals during treatment with the drug (see recommendations under "Important Note and Precautions") to help in the early detection of serious bone marrow injury. Abnormalities in initial blood tests should rule out use of the drug. Also, patients should be made aware of such early toxic signs of a potential hematologic problem as fever, sore throat, mouth ulcers, easy bruising and petechial or purpuric hemorrhage. Should such signs appear, the patient should be advised to discontinue the drug and to report to the physician immediately.

Indication Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia. It is not a simple analgesic and should never be administered for relief of trivial facial aches or pains.
Contraindication Do not use in those with a known sensitivity to any tricyclic compound or in those being treated with M.A.O.I. agents. As long a period as possible should elapse before using Tegretol in patients who have been treated with M.A.O.I.'s, with a minimum of 7 days. In such cases, initial dosage should be low and the patient's reaction to gradual increments closely observed.
Important Note and Precautions Familiarity with the clinical symptoms which lead to an accurate diagnosis of true trigeminal neuralgia and with the complete prescribing information, careful patient selection, a thorough examination before treatment and close patient supervision throughout the treatment period are essential to the safe and effective use of this drug.
Where feasible, Tegretol should not be used in conjunction with any potent drug which may increase the possibility of toxic reactions.
In pregnancy, the drug should not be prescribed during the first trimester and thereafter only to patients in whom the clinical situation warrants the potential risk. It should not be administered to nursing mothers.
Patients with increased intraocular pressure should be closely observed during treatment with this drug because of its anticholinergic effect.
Because of the drug's relationship to other tricyclic compounds, the possibility of activation of latent psychosis and, in the elderly, of confusion or agitation, should be considered.
Dizziness and drowsiness may occur and patients should be cautioned about the hazards of operating machinery or automobiles and of engaging in other hazardous tasks.
Use cautiously in patients with a history of coronary artery disease, organic heart disease, congestive failure or liver disease.
Before initiating therapy, the following laboratory procedures should be performed:
1. Complete blood and platelet counts which, if abnormal, should rule out the use of the drug.
2. Baseline evaluations of liver function.
During treatment with Tegretol, the following laboratory procedures should be performed:
1. Complete blood and platelet counts should be done at intervals of one week during the first month of drug treatment, every two weeks during the second and third months, and at monthly intervals thereafter for as long as the patient is taking the drug. A trend toward a decreasing white blood cell count should suggest a dosage reduction and more frequent laboratory and clinical evaluations. Should this trend continue, the dru should be discontinued.
2. Liver function tests must be performed at regular intervals during tre ment with this drug since liver damage may occur during therapy. The drug should be discontinued immediately in cases of aggravated liver dysfunction or active liver disease.
3. Periodic eye examinations, including slit-lamp, funduscopy and tonor etry, are recommended for patients being treated with this drug since many phenothiazines and related drugs have been shown to cause eye changes.
4. Complete urinalysis and BUN should be done on patients treated w Tegretol because of observed renal dysfunction.
Adverse Reactions Dizziness, drowsiness, unsteadiness on the feet, nausea, vomiting, aplastic anemia, transitory leukopenia, agranulocyto eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormalities i liver function tests, cholestatic and hepatocellular jaundice, urinary fre quency, acute urinary retention, oliguria with elevated blood pressure, albuminuria, glycosuria, elevated BUN, microscopic deposits in the uri impotence, disturbances of coordination, confusion, headache, fatigue blurred vision, transient diplopia and oculomotor disturbances, speech disturbances, abnormal involuntary movements, peripheral neuritis an paresthesias, depression with agitation, talkativeness, nystagmus, tinnitus, paralysis and other symptoms of cerebral arterial insufficiency, pruritic and erythematous rashes, urticaria, Stevens-Johnson syndrom photosensitivity reactions, alterations in skin pigmentation, exfoliative dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, eryt multiforme and nodosum, aggravation of disseminated lupus erythema tosus, gastric distress, abdominal pain, diarrhea, constipation, anorex dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills, adenopathy, lymphadenopathy, aching joints and muscles, leg cramps conjunctivitis, left ventricular failure, aggravation of hypertension, hyp tension, syncope and collapse, edema, aggravation of coronary artery disease and congestive heart failure. (Whether these cardiovascular e are drug-related is not known. However, some of these complications resulted in fatalities.) The necessity for discontinuing the drug should dictated by the gravity and severity of the adverse reactions.
Dosage and Administration The drug should always be taken with me if possible.
Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, the dose should be increased in one-half tablet (100 mg.) increments every 12 hours until freedom from pain is achieved. To relieve pain, between 200 mg. and 1200 mg. per 24 hours may be necessary.
Maintenance: Initial control of pain can be maintained in most patients with a dose of 400 mg. to 800 mg. daily. Maintenance doses may range between 200 mg. and 1200 mg. daily.
At least once every 3 months during treatment period attempts should be made to discontinue the drug or to reduce the dose to the minimum effective level.
Availability Round, white, single-scored tablets of 200 mg. in bottles of 100 and 1000. (B)46-820
For complete details, please see Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Geigy

uncommon relief of uncommon pain





A little

Just one 50 or 100 mg.
tablet in the morning c
work a long diuretic d
in edema and hyperte

HY-6113



elygroton® can work a long day too

lorthalidone

at s because of its prolonged
ion, usually providing smooth
retic activity throughout the day.
d one-a-day dosage, in the
g run, means few tablets to take
d few tablets to pay for.

Hygroton, brand of chlorthalidone, may mean troublesome side effects for certain patients. And you can't prescribe it in cases of demonstrated hypersensitivity to the drug or in severe renal or hepatic diseases.

Before writing it for your patients, please check the Prescribing Information. It's summarized on the next page.

lygroton

lorthalidone in edema and hypertension

Geigy



in edema and hypertension

A little Hygroton® can work a long day

chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant patients. Since the drug may cross the placental barrier, adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, hyperuricemia, headache, muscle cramps, orthostatic hypotension, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.

(B)R2-46-230-D

For full details, please see the complete prescribing information.

Geigy

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

HY-6213

The muscle relaxant that works before you write a prescription

Relieve painful skeletal muscle spasm in your office in minutes with a single 2 cc. injection of NORFLEX. Then, for sustained relief, write a prescription for NORFLEX tablets, 1 tablet b.i.d.

CONTRAINDICATIONS: Due to its anticholinergic action, NORFLEX should not be used in patients with glaucoma, pyloric or duodenal obstruction, stenosing peptic ulcer, prostatic hypertrophy or obstruction at the bladder neck, cardiospasm (megaesophagus) and myasthenia gravis. Use with caution in patients with tachycardia. Do not use propoxyphene (Darvon®) concurrently.

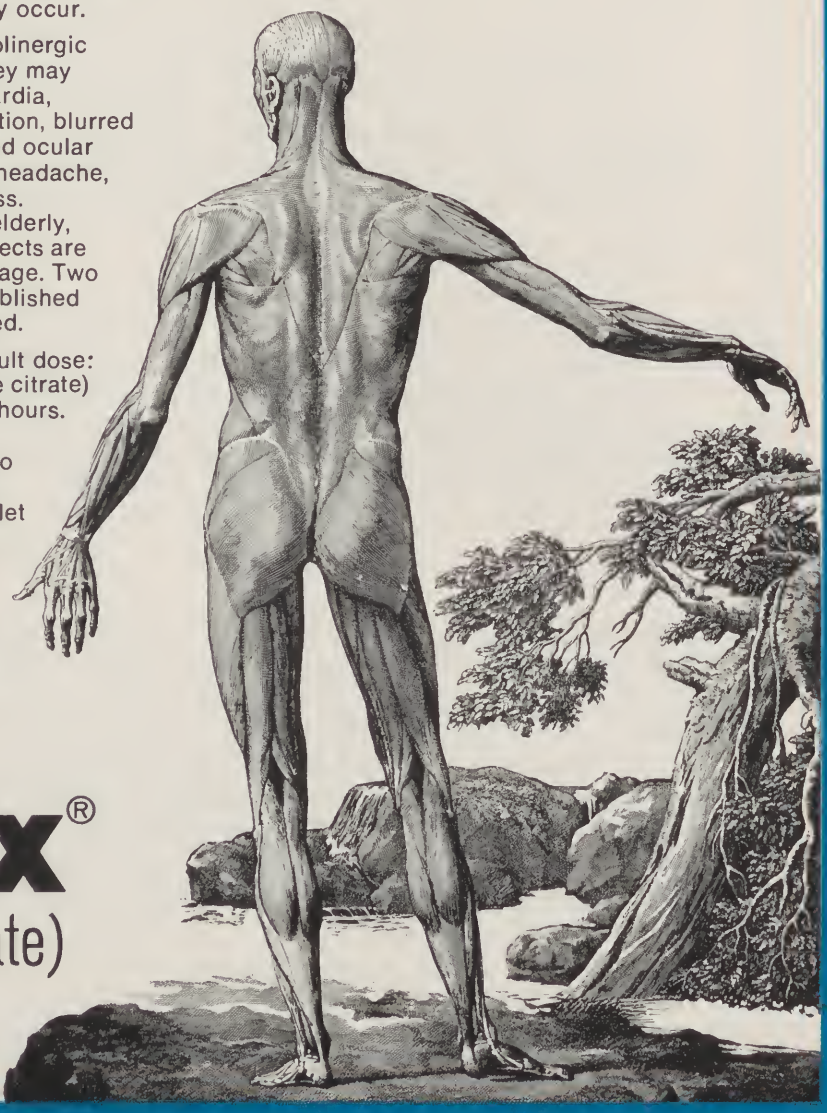
WARNING: Transient lightheadedness or dizziness following NORFLEX-INJECTABLE may occur.

SIDE EFFECTS: Due mainly to anticholinergic action and usually at high dosage. They may include dryness of the mouth, tachycardia, palpitation, urinary hesitancy or retention, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, and drowsiness. Infrequently, mental confusion in the elderly, urticaria or other dermatoses. Side effects are usually eliminated by reduction in dosage. Two cases of aplastic anemia, with no established causal relationship, have been reported.

DOSAGE: **INJECTABLE** — Average adult dose: one ampul, 2 cc. (60 mg. orphenadrine citrate) I.M. or I.V. May be repeated every 12 hours. Relief may be maintained with one NORFLEX tablet b.i.d. **TABLETS** — Two tablets per day for adults, one in the morning, one in the evening. Each tablet contains 100 mg. orphenadrine citrate.

For full information, see Package Insert or P.D.R.

Riker Laboratories
Northridge, California 91324



Norflex®
(orphenadrine citrate)

Editorial
Maryland State Medical Journal
Vol. 17, No. 7
July, 1968

GENERIC

Governor Agnew has vetoed the bill which would have required physicians to prescribe drugs generically. *The Morning Sun* in an editorial on May 17 asked the authors and sponsors of the bill to eliminate the "bugs" in it and resubmit it.

Every advocate of the bill stresses the point that drugs prescribed by generic names will be cheaper. Every opponent of the bill claims that the quality of the drug dispensed will be inferior.

When *oxytetracycline* first appeared on the drug market I prescribed it generically—but for five days only because I could not tolerate the telephone harassment . . . pharmacists would call and ask what the drug was, or which manufacturer's product I wanted them to use. If generic prescribing becomes the "in-thing" this specific problem will disappear, but it is a point to note in passing.

Generic prescribing will *not* per se lower the cost of the dispensed drug for the simple reason that the pharmacist will have an option to fill the prescription with either the least expensive or the most expensive drug which fits the generic formula. (Ed. Note: According to a well-known market research firm only 27% of the top 200 most frequently prescribed drugs are available generically.) Generic prescribing by the physician will *not* affect the practice of pharmacy in any way except to provide the pharmacist with wider latitude in choosing the drug to dispense.

Hospitals and some nursing homes have adopted Formularies listing the drugs stocked, from which listing the physician may choose the drug he desires his patient to have. The Maryland State Health Department is developing a Formulary for use in the Medicaid program.

A Formulary is restrictive in the sense it endeavors to hold the line on price by including the cheaper medications, yet it is sufficiently permissive or liberal in that it encompasses enough of the same type of drugs to give the prescribing physician leeway or choice, satisfying his professional therapeutic acumen. A real advantage is built into the Formulary . . . if a physician urgently desires an unlisted drug for a particular emergency, he has the right to

PRESCRIBING

order it, and is assured that it will be obtained and administered. The important thing is that quality does not suffer in this process, provided the physician is knowledgeable enough to recognize a real drug "turkey" in the listing and will have no part of it.

Detail men are the "pitch" men of the pharmaceutical industry. They can supply the physician with valuable information regarding drugs but after that it's up to the physician.

When considering a new drug, the first thing to look for is its contraindications and its side effects. If these are minimal the rest of its claims are worth further consideration. If they look like the warning to humans on a can of insecticide, forget it. If after these considerations the drug looks good and seems worthy of prescribing, then its cost to the patient certainly does deserve study.

When the detail man has finished his presentation, he should furnish the physician a price list of all his products, with assurance that on subsequent visits any amended lists will be provided. The physician at his leisure then can compare the various drugs he is offered not only on a level of therapeutic excellence but on a price level. He is then free to prescribe the best drug for his patient at the least cost. This approach has the blessing of the AMA, and Dr. Rouse, its president. I do not believe anyone can quarrel with it.

Summary:

- Generic prescribing per se will *not* lower the cost of drugs to the consumer.
- The Formulary is a *better* way to control the cost of drugs without sacrificing quality.
- The prescribing physician who knows both quality and cost of drugs is the *best* guarantee of low-cost high-quality medicine for every patient.

JOHN F. SCHAEFER, MD
Baltimore

Temporal arteritis, otherwise called giant cell arteritis or cranial arteritis, is a disease occurring after age 50, with loss of vision in one eye occurring 40-50% of the time, and in both eyes 25% of the time. Paresis of extraocular muscles with resulting diplopia occurs about 10% of the time. An increased erythrocytic sedimentation rate is almost always found, and a positive diagnosis can be made on the characteristic histological findings on temporal artery biopsy. Early recognition is important since treatment is often effective in preventing visual loss, but rarely results in recovery once vision is gone.

TEMPORAL ARTERITIS: A CAUSE OF BLINDNESS

R. D. RICHARDS, MD
Professor and Head, Department of Ophthalmology
University of Maryland School of Medicine

Temporal arteritis is a disease of the elderly and in the classical case the temporal arteries are thickened, prominent, pulseless, and painful to touch. The condition is rare under age 50, and the earliest documented case was in a 35-year-old man.[1] It is most common in the sixties and seventies. The course is chronic, and lasts about six months. Severe headaches, weight loss, low grade fever and an increased erythrocytic sedimentation rate are usually present. It is an inflammatory disease of unknown etiology, and the arteries involved are larger than those affected by polyarteritis nodosa. Not only cranial vessels, but also the aorta, carotids, and major trunk arteries have been found to have the typical histological changes. However, symptoms almost never occur from arterial involvement outside the cranial group. The clinical signs and symptoms associated with temporal artery involvement led to the name "temporal arteritis." With the recognition that other arteries were involved, different names have been suggested. The two most commonly used are "cranial arteritis" and "giant cell arteritis." These are based on the area most commonly affected, and the histological changes in the arteries.

Microscopic examination showed narrowing or occlusion due to fibroblastic necrosis of the media with destruction of the elastic lamina, with granulation tissue containing multinuclear giant cells.[2] The most common complication is blindness from occlusion of the arteries supplying the globe and optic nerve. About 40-50% of patients with this disease have loss of vision in one eye, and 25% have both eyes involved, usually one eye preceding the other. Diplopia from paresis of extraocular muscles has been reported in 12% of patients.[3, 4]

Cerebral ischemia from cerebral vascular involvement can also occur, but is much less frequent. Patients rarely die from this disease, and recovery over a period of months is the usual course. However, patients are incapacitated by the pain and weakness during the course of the disease, and disability from blindness occurs in a significant number. Early treatment is most effective in reducing these complications.

Two case reports emphasize some of the important clinical aspects of this disease.

Case Reports

Case #1—A 72-year-old woman was first seen in October, 1966. She had noted progressive weakness for four months, associated with dizzy spells, headaches and loss of vision in the right eye for several weeks. She had taken oral medication for diabetes mellitus for four years.

Examination of the forehead was normal, and no tenderness or swelling over the temporal arteries was found. Vision in the right eye was reduced to counting fingers at two feet. The right pupil was slightly larger than the left, and reacted to light sluggishly. On ophthalmoscopic examination the disc was pale with blurred edges. Vision in the left eye was 20/30, and the fundus was normal.

Laboratory examination included an elevated fasting blood sugar and an elevated erythrocytic sedimentation rate. The EKG showed changes compatible with myocardial ischemia. Two lupus erythematosus examinations were normal, as was the chest X-ray. The hemoglobin was 7.8 gm%, and the white blood cell count was 6,250 cells/cu mm.

The temperature on admission ranged from 100° to 100.5° Farenheit. Prednisone orally was started, and the temperature returned to normal. Headache and other symptoms stopped, and the patient had a sense of well-being. A temporal artery biopsy was done, and the report positive for temporal arteritis (Fig. 1).

Over the next two weeks the temperature remained normal, and all symptoms were gone. Despite continuing prednisone, the vision in the right eye remained counting fingers at two feet, and the vision in the left eye decreased from 20/30 to 20/50.

Case #2—A 79-year-old woman was first seen in January, 1968. She had had severe headaches and progressive weakness for six weeks prior to admission. Three days before admission to the hospital she woke with only light perception in the right eye, and 48 hours later she lost most of the vision in the left eye. At the time of admission she had a severe headache. She could hardly walk because of weakness. The temporal arteries could be easily palpated on both sides, but were not tender. Both pupils were moderately dilated and reacted sluggishly to light. Ophthalmoscopic examination showed both discs were pale with blurred margins and had cotton-wool exudates (cytoid bodies) adjacent (Figs. 2 & 3). Vision was reduced to light perception on the right and counting fingers at three feet on the left. Lumbar puncture was done, with normal pressure and spinal fluid chemistries. Skull and chest X-rays were normal. The erythrocytic sedimentation rate was elevated, and other laboratory examinations were normal.

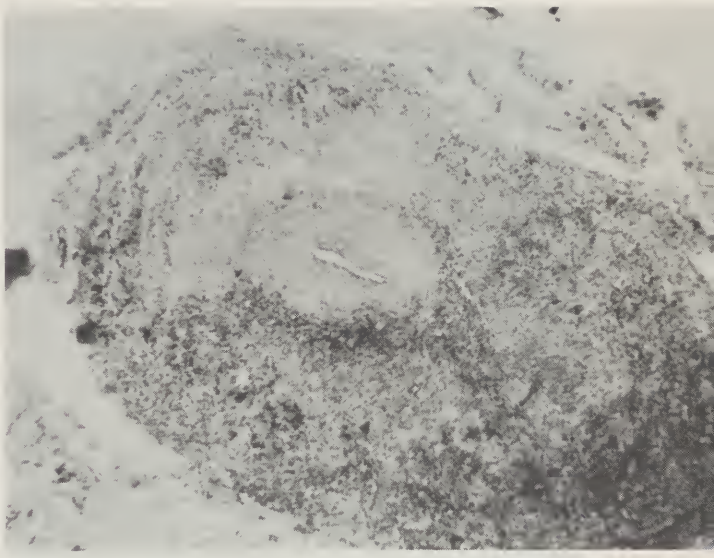


***Figure 1*—Temporal artery almost completely occluded; with granulation tissue containing multinuclear giant cells characteristic of temporal arteritis (×30).**

Prednisone orally was started the day of admission, and all symptoms were gone within 12 hours. Temporal artery biopsy, done three days after admission, was compatible with temporal arteritis. She was discharged four days later, on oral prednisone, with the erythrocytic sedimentation rate still elevated. The vision was not improved. After three weeks treatment on prednisone as an outpatient, vision in the right eye remained the same, but vision on the left improved to 20/80, although the visual field remained markedly constricted.



Figure 2—**Right eye; disc is pale with blurred margin, and large cotton wool exudate adjacent on the temporal side.**

Discussion

The typical course of temporal arteritis includes gradual onset of severe headaches, malaise, and weight loss, with low-grade fever. Localized tenderness on palpation over the temporal arteries associated with swelling is an important clinical finding, but absence of these changes does not rule out temporal arteritis. An elevated erythrocytic sedimentation rate is almost always present. Diplopia from paresis of extraocular muscles may occur also, and should arouse suspicion. Visual loss often does not occur until a month or so after the onset of the disease, but may precede all other signs and symptoms at times. Typically, vision is lost in one eye first, usually leaving only light perception. The pupil of the eye involved is larger than the opposite one, and reacts poorly to light.

Ophthalmoscopic examination usually shows one of two characteristic pictures.[5] Most commonly, the disc is slightly swollen, pale, with blurred margins. A few hemorrhages may be present around the disc, and cotton wool exudates (cytoid bodies) are often seen. The rest of the retina is normal. This picture, with sudden loss of vision, should arouse the suspicion of temporal arteritis. The second cause of blindness due to temporal arteritis is less common, and is an occlusion of the central artery, with narrowing of the retinal arterioles and a cherry-red spot in the macula from edema of the retina. An occlusion of the central retinal artery should alert the physician to the possibility of temporal arteritis, but does occur more commonly as the result of other vascular diseases. A normal appearing disc with loss of vision from retrobulbar neuritis due to temporal arteritis has been reported but is not typical. Sudden loss of vision in any patient over 50, however, should suggest the possibility of temporal arteritis.

The diagnosis can be confirmed by a biopsy of the temporal artery. If one eye is involved, the temporal artery on that side should be biopsied. Even if the temporal artery is non-tender and has good pulsation, biopsy should be done and may be positive. However, patchy involvement is

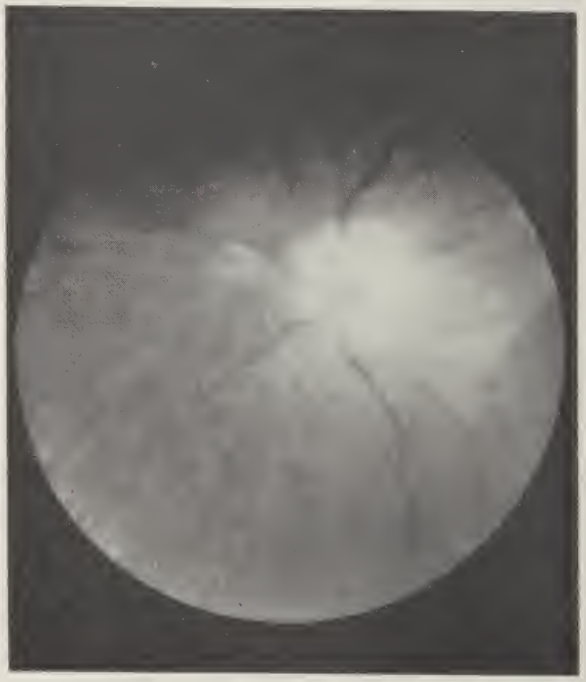


Figure 3—**Left eye; disc is pale with blurred margin, with a splinter hemorrhage and cotton wool exudate on the temporal side. Vision, counting fingers at three feet.**

characteristic, so a negative report does not exclude the diagnosis of temporal arteritis. The biopsy can be done with local anesthesia as an office procedure.

If one eye has visual loss, and the clinical diagnosis is temporal arteritis, treatment should be started immediately to prevent visual loss in the other eye, and should not wait for a report from the temporal artery biopsy. If necessary, the biopsy can be delayed a few days after starting treatment. Therapy is most effective in preventing loss of vision, and usually return of vision does not occur once lost despite adequate therapy.[6] Treatment consists of corticosteroids; intravenous if there is real urgency. Some recommend anticoagulants, but our experience has been that these agents do not significantly alter the course, and add additional hazards. The erythrocytic sedimentation rate should fall with adequate therapy, and this, plus the symptoms, should be used to determine the level of dosage. This level should be maintained for about two weeks and then gradual reduction begun. As long as the symptoms and sedimentation rate are controlled, reduction can continue, but a maintenance dose is often necessary for six months or longer. Recurrences with vision loss can occur if therapy is reduced or stopped too rapidly. Care should be taken also to avoid stress during the active stage of the disease. Patients have lost vision after elective surgery despite doses of corticosteroids sufficient to control symptoms and maintain a normal sedimentation rate.[7]



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*Jesse C. Coggins Fund Lecture**

THE CARE O

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Diabetes can be described as unstable or "brittle" when it behaves in an erratic and unpredictable manner in spite of meticulous attention to factors of diet, physical exercise, and insulin.[1-3] Unstable diabetes constitutes a small proportion of the diabetes ordinarily described as juvenile, growth-onset, or ketosis-susceptible. Many, perhaps most, persons having juvenile diabetes find that, with reasonable attention to routines of diet and insulin, they do not experience insulin reactions or excessive glycosuria with enough frequency to be a major problem.

Juvenile diabetes is characterized by susceptibility to keto-acidosis. Commonly, juvenile diabetes is discovered when symptoms of keto-acidosis evolve over the space of a few days. Ordinarily, little or no insulin can be extracted from the pancreas of the juvenile diabetic, and there is doubt whether insulin measured by various biologic or immunologic techniques in the blood represents effective insulin secreted by the pancreas. For practical purposes, the juvenile diabetic can be thought of as a person unable to manufacture insulin who must receive insulin by injection in order to survive. Omission of insulin injections inevitably leads to keto-acidosis.

Whereas juvenile diabetes ordinarily begins in childhood or early adult life, occasionally diabetes of this character may begin in later life. It is possible in such circumstances to describe the 50- or 60-year-old person who has recently discovered ketosis-susceptible diabetes as being a juvenile diabetic.

The sulfonylureas (tolbutamide, chlorpropamide, acetohexamide, and tolazamide) appear to exert their hypoglycemic effects through stimulating insulin release from the beta cells. Juvenile diabetics have little or no insulin in their islets, and hence will not respond to the sulfonylureas.

The juvenile diabetic characteristically is lean, possibly because of intermittent wastage of calories in the form of glycosuria. Small variations in insulin dose often cause substantial differences in glycosuria and blood sugar levels. In contrast, the adult or maturity-onset diabetic rarely has had keto-acidosis. Frequently, diet alone will control the carbohydrate disturbance. Often the adult diabetic will be obese; perhaps because obesity increases the need for insulin. A marginal ability to manufacture insulin may mean frank diabetes in the obese person, whereas a lean person with the same capacity to manufacture insulin may have a normal result of the glucose tolerance test.

When the adult-onset diabetic requires insulin, considerable changes in insulin dose may cause relatively little change in results of urine and blood tests.

Insulin can be measured readily in the blood of the person having maturity-onset diabetes, and the pancreas contains nearly normal quantities of

* Presented April 19, 1968, Baltimore, during the 170th Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland.

insulin. Usually, the sulfonylureas cause release of insulin from the pancreas, and often this is sufficient (in addition to diet) to control the diabetes satisfactorily.

Possible Causes of Brittleness

Ordinarily, no specific cause for true "brittleness" can be found. Such endocrine disorders as pituitary insufficiency and adrenal insufficiency are usually readily identified, and should be considered if insulin requirement is low and insulin reactions are a major problem.

Pregnancy is an endocrine "disorder" which tends to be diabetogenic. Rising insulin requirements during the second and third trimesters may lead to keto-acidosis if the insulin dose is not increased rapidly enough. For several days after delivery, the diabetic woman is exquisitely sensitive to small doses of insulin as though she had pituitary insufficiency. Giving the usual dose of insulin on the day of delivery may cause catastrophic hypoglycemia.

Cushing's disease or glucocorticoid therapy may aggravate diabetes, but such steroid diabetes is usually of the stable variety.

One can speculate that varying degrees of insulin resistance, changes in growth hormone or glucagon levels, or alterations in amount of hepatic enzymes that control carbohydrate metabolism may contribute to instability but no simple and general explanation can be given.

What Is to Be Done for the Patient Having Brittle Diabetes?

First, the physician must be certain that the diabetes is truly brittle. Many patients will seize on this term and announce to everyone that their diabetes is brittle, with the implication that efforts at careful dietary and insulin management will be to no avail. The answer to this is that the truly brittle patient is the one who needs the very greatest attention to details of diabetic management. Often a person with relatively stable diabetes will appear to have brittle diabetes because of various therapeutic errors and failure to follow the ordinary rules of diabetic care.

Perhaps the most common errors involve insulin. The person may be led to take excessive amounts of insulin because of isolated blood sugar values that are elevated, or perhaps adjustments of dose are made in excessively large increments. Supplements of regular insulin given in addition to a morning dose of intermediate insulin, in amounts of 6 to 24 or more units at various hours of the day, depending on the results of the urine test of the moment, may be very helpful in managing acute illnesses, but may lead to reactions and apparent instability if given in the ordinary daily care of the diabetes in any substantial amount.

Many juvenile diabetics have small amounts of acetone in their urine from time to time even if control is satisfactory. If such a finding of acetone leads to the taking of supplements of insulin, hypoglycemic episodes are likely. It is sometimes necessary to tell the diabetic who is concerned about positive tests for acetone not to test for acetone unless he has been having heavy glycosuria for a specified length of time.

Some glycosuria after meals is almost inevitable in juvenile diabetes. By testing "fresh" urine specimens before meals and at bedtime, the postprandial spill can be ignored. Patients should be instructed to empty the bladder, wait 20 to 30 minutes, and then collect the sample to be tested. The sample then should be representative of the state of the diabetes during those 20 or 30 minutes. Failure to test fresh samples could lead to unnecessarily large doses of insulin and hypoglycemic episodes.

In the same manner, a bladder with neurogenic dysfunction could lead to insulin reactions in the face of glycosuria. Less often there may be a true renal glycosuria, which may entice the diabetic to give himself excessive amounts of insulin.

Injection techniques should be reviewed in detail. Many veteran diabetics are reluctant to change long-standing habits and often are confident that their way is best. Insulin given into lipohypertrophied areas may have appreciably less effect and hence lead to glycosuria; an injection of the same dose into a "fresh" area may cause hypoglycemia. Hence, rotation of injection sites and avoidance of hypertrophied areas are important.

Some diabetics eat, exercise, and sleep erratically and thus may give the appearance of instability. Regularity of daily routine including timing of meals, amount and time of exercise, and hours of sleep are paramount in the care of truly brittle diabetes. Exercise tends to reinforce the action of insulin, unless the level of blood sugar is rather high, and may cause reactions. If exercise outside of the usual routine is necessary, it is usually better to take additional food at the moment rather than attempting to lower the dose of insulin.

Undue concern about reactions may cause the anxious diabetic to eat excessively when he suspects he is having hypoglycemic symptoms. Because most of the early symptoms of hypoglycemia are the result of release of epinephrine, the patient may find symptoms of anxiety attacks and of hypoglycemia indistinguishable. Furthermore, anxiety and release of epinephrine could contribute to instability of blood glucose.

The use of monoamine oxidase inhibitors may lessen the ability of the body to compensate for insulin-induced hypoglycemia.

Care of Brittle Diabetes

If the patient has truly brittle diabetes, then he must be prepared to pay meticulous attention to many details.

Diet must be consistent from day to day in kind, amount, and timing. Often weighing of the portions of food will contribute to accuracy. Usually midafternoon and bedtime feedings will be necessary. Proportional size of meals and feedings may need to be changed to prevent glycosuria or hypoglycemia that occur consistently at a particular hour. For instance, nocturnal hypoglycemic episodes and excessive glycosuria before lunch might be corrected by decreasing the size of breakfast and increasing the bedtime feeding.

The entire daily routine should be kept as consistent from day to day as possible. Exercise, hours of sleep, and timing of meals should be kept as constant as feasible.

The choice of the kind of insulin, the dose, and the timing of injections is perhaps the most crucial part of management of highly unstable diabetes.

A single dose of intermediate insulin such as Lente or NPH will be successful in most insulin-requiring diabetics if the dose is adjusted slowly in small increments, and if dietary precautions are observed. Daily changes in dose of more than 4 or 6 units may lead to an appearance of brittleness.

Even with careful timing and proportioning of meals, and with proper adjustment of dose, a single injection of intermediate insulin may not control the truly brittle diabetic. Excessive glycosuria during the day may require addition of regular insulin to the NPH or Semi-Lente insulin to the Lente. The amount of the more rapidly acting insulin is adjusted in small increments at intervals of a few days, depending on the amount of glycosuria during the day. Excessive glycosuria during the evening and night may be treated appropriately by a second dose of insulin, either a rapidly acting or an intermediate one, before supper. Patients should understand that one day's urine tests are not an accurate index of what that day's insulin will accomplish, that there is enough day-to-day variation so that using the same dosage for several days is commonly advisable. They should also understand that only by keeping accurate records of urine test results can they control their diabetes properly.

A few patients with very unstable diabetes may profit from a program of four injections of regular insulin per day, one before each of four nearly equal feedings. Such a program may be inconvenient, but it permits rapid correction of excessive glycosuria and seems less likely to produce symptomatic hypoglycemia, perhaps because the action of the regular insulin is waning about the time that absorption of food is completed.

There is no simple answer to the problem of "brittleness." Only by meticulous attention to many details will the brittle diabetic achieve reasonable control.

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Any physician today whose interest extends beyond the immediate circumstances of his own career and encompasses the future of the medical profession as a whole must often feel that he could well declaim along with Shakespeare's Hamlet:

"The time is out of joint; O cursed spite,
That ever I was born to set it right!"

Certainly the time does appear to be out of joint, and members of the medical profession must accept the responsibility of providing leadership in setting it right.

The situation of the profession and of the entire health care field seems to be a series of incredible paradoxes which defy easy solution.

Problems of a Free Health Market

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As patients, people respect their individual physicians; but as members of the public, those same people may seriously question the motives and methods of the medical profession.

More advances in the science of medicine and in the techniques of care have been developed in the last 20-odd years than in all of previous history; yet it is during recent years that the clamor has arisen for changes in the functions of the medical profession.

There are now more physicians and more health care personnel than ever before; but many shortages exist throughout the field.

In summary, it can be said that in a large sense, medicine and its practitioners never had it so good. In another, equally large sense, however, medicine and its practitioners never had it so bad.

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As Individuals, Physicians Enjoy a Great Many Advantages

The individual physician of today is well-accepted by his patients, his colleagues, his peers, and the public. He is looked upon as a highly educated and well-trained person; as an effective practitioner of the science and art of medicine. He enjoys a prestigious position in society; has a good life with a good income; and has a busy, demanding but rewarding career from the standpoint of intellectual and emotional satisfactions as well as economic and material rewards.

However, in spite of the favorable recognition they enjoy as individuals, members of the medical profession collectively are facing bad times. The social, political, and economic climate of today is not favorable; and there are indications that it may be worsening.

One reason is the dichotomy of opinion that people hold toward the single physician and the

medical profession. As a fairly simple documentation of that contrast, consider the results of the survey taken in more than 400 randomly selected households in Monroe County, New York, as reported in a November issue of *JAMA*.

Regarding their own physician, respondents reported overwhelmingly that their doctor does not keep them waiting too long . . . spends enough time with them . . . is willing to listen to problems . . . is sympathetic about personal and medical problems . . . and provides a good examination. From 83 to 97% of the respondents affirmed those positive features of their personal medical care.

By contrast, answers to questions about medicine in general made the same respondents sound like a different group of people.

Slightly more than half said yesterday's family doctor gave better care than today's modern specialist. Six out of ten accused doctors of being selfish and interested in their own financial gain. Forty per cent said doctors are so impersonal and scientific that they do not take a great deal of interest in their patients' problems. Half reported that the way medicine is practiced today, the patient often is sent from one costly specialist to another without finding out what is wrong. And a little more than 40% said the AMA works to protect the interests of the doctor more than to maintain a high level of health care in the nation.

In view of that kind of evidence, the wise physician no longer can believe that because he is a dedicated, well-informed practitioner, he is doing everything necessary to assure continuation of his present practices and those of his colleagues.

Today's physicians—and even more, their successors—may be in real jeopardy of social pressures that could relegate them to a far less noble role in society than they traditionally have played. And although the pressures undoubtedly will be exerted for the ultimate good of society, as the public sees that good, the end result probably would be less desirable and could be disastrous, not only for the profession but for the very public which our profession is trying to serve.

One of the most significant and most frustrating of the paradoxes in the present situation is that the pressure to revise the system of delivering health care has developed during the period of the greatest medical advances and most outstanding successes.

A truly impressive array of victories has been scored in the last generation in science, in medical research, in medical education, and in medical services. But that very success has been one of the major factors in the growth of a vastly increased demand for health services—not only by individuals, but also by both private and governmental agencies and organizations seeking medical benefits for their members or those for whom these groups feel responsible.

Increased demand—brought about also by such additional factors as increasing population and the growing affluence of the majority of citizens—has generated another of the paradoxes: shortages of health facilities and personnel in the midst of plenty.

The U. S. has More Health Facilities, More Health Manpower Than Ever

This country has more hospitals than all the remainder of the world. The number of physicians has increased more rapidly than the general population, and the same is true for allied professions and occupations.

The ratio of physicians to allied personnel, which was 1 to 10 not long ago, has reached 1 to 13; and is expected to reach 1 to 17 early in the next decade.

Yet, the demand for services has outstripped both the facilities and personnel available to provide these services. The health field now faces the third largest market in the United States; a market that very likely will become the largest by 1975. Expenditures for health care approach $50 billion a year and will continue to rise.

This situation of rising demand creating shortages of facilities and personnel has brought about the public pressure for newer and better methods of providing care to all of society.

To prevent that pressure from overwhelming and constricting medical practice to the point where both physicians and their patients may suffer irreparable harm, physicians must enlarge their sense of responsibility. They must be knowledgeable in more than the scientific techniques of medicine, they must be knowledgeable also of all the circumstances under which medicine is being practiced and be well acquainted with the variety of questions being raised about medicine's mission and how society might want that mission modified.

Furthermore, physicians must provide leadership in formulating answers to those questions.

This problem is not unique to the United States. Because of this nation's heritage of freedom, pri-

vate enterprise, and individual initiative, it is only late in arriving. It has already developed in many other countries, particularly in Western Europe.

An outstanding example is Great Britain, whose system of health care has been cited as ideal by virtually every proponent of national medical programs for this nation. In Britain, the arguments of physicians were successfully interpreted as being self-seeking and were overwhelmed by political and public pressure for universal health care financed by the government.

This was done, and its implementation has impaired research; has failed to create educational facilities; has lessened the amount and often the quality of care available to patients; and has placed such restrictions on the life of the physician that many have found it intolerable and have left their country.

The result has been the lessening of the availability of medical care because the patient load on remaining physicians became overbearing; and of the quality of care because some of the emigrants had to be replaced by foreign physicians who were less well trained and less qualified to serve. Gresham's Law that the bad drives out the good under certain circumstances does not apply only to monetary systems.

There are indications—much to the dismay of anglophiles among this nation's advocates of federal health care for all—that the government of Britain has serious doubts whether that country can continue to afford luxuries such as universal, "free" medical care, particularly when combined with many other welfare programs. British economists have pointed out that heavy social spending has used up treasury funds that might have been spent better on more pressing national problems, such as developing export industry.

Britain's Minister of Labor was recently quoted as stating that it is time for what he called a "constructive argument" about the way vast sums are paid in social benefits. In a speech, he asked whether such benefits should be provided . . . "to those whose financial position makes them unnecessary? Or, alternately, should not the available resources be concentrated on those in the greatest need?"

The United States is faced with a developing situation which could become similar. Already there is a plethora of health legislation, for the implementation of which the federal government is spending huge amounts of its tax resources—while conducting a war and supporting simultaneously a wide variety of other welfare programs.

Physicians and others in the health field must be aware that there is a consolidation of forces in this country supporting the expansion of federal involvement in, and intrusion into, the health field. Even giving those forces credit for being sincerely well-meaning, some of their premises can be questioned.

They see medicine as the entitlement of all citizens, regardless of economic status, location or other factor.

They say medical care should be available under all conditions, in all locations, around the clock and around the calendar, to satisfy health needs.

Most significantly, however, their belief is that some other party—sometimes unnamed, but usually designated as the federal government—should pay for the services rather the patient himself being responsible for any of the cost.

The latter premise is supported by certain labor leaders; by an apparently large group that has been accumulated in the executive branch of government; by members of the so-called liberal sector, in education and in the press; and by some among the public.

Their contention looks good at short range. Certainly they have done a marvelous job of marketing their point of view: It is in the public interest and is the rightful role of government to finance all health care. But, they appear to have given little or no thought to the ultimate cost to the taxpayers of this nation.

They also have not considered the strictures that such a system could impose on the profession and its ability to serve the people.

There is little reason to believe that results here would be significantly better than those in Great Britain, where there is virtually a scientific sterility; with very few new ideas in science having been developed since the imposition of national controls over the field of medicine.

The medical profession has not made itself popular with many persons by its opposition to universal governmental health programs. We have been accused of seeking only to maintain an antiquated status quo; and to strengthen our own financial position. Such accusations are not true.

Regardless of the immediate consequences in adverse public opinion generated by medicine's opponents in this matter, the medical profession is on solid ground, both morally and economically, in continuing to press for recognition of the fact that tax money spent on health should be limited

to those who can demonstrate need; and further, that need should be determined locally.

There are a number of ways to pay for health care. The most economical and prudent is cash. In addition, there is postpayment, which people use every day when they buy appliances, automobiles or anything else they want. Another is insurance or the prepayment mechanism. And finally, tax funds are—and should be—available for those not able to meet their medical needs in any of the other ways.

With that much background of the problems that exist and the problems that are developing in the form of solutions with which our profession and many others cannot be in sympathy, let us turn to some of the answers the medical profession can and must give to questions that are being raised.

How to Help the Public Face the Problems of the Inflation of Health and Medical Care Costs.

In this crucial time, every physician has to recognize that not only is he caught up in the general inflation that affects every aspect of life, but he also is caught up in the very special inflationary effects that come to bear particularly on the health care field. This circumstance has come about because of the insatiable demands of a society that has committed cash, insurance, and tax dollars in huge amounts to a field in which the available amount of talent and facilities is relatively limited.

One thing that makes the problem worse is the attitude of surprise with which the supporters of federal health programs have publicly greeted the inflation of health care costs. These proponents act as though there were no possible suspicion that anything like that could have happened; and, because they have access to a great deal more space and time in the news media than medicine has, they have been able to pass their shocked indignation along to the public.

What is not remembered by much of the public and is ignored by those who are seeking to put all of the blame onto medicine is the fact that for years the AMA predicted that medicare, if passed, would be highly inflationary. It has been.

Medicaid also is inflationary, along with the two dozen or so other bills passed by the 89th Congress to involve the direct expenditure of federal tax funds for health care for various segments of the population.

Medicine already was in a rising market, because of other factors which had increased demand, when all of this legislation was passed. When an additional five to six billion dollars was infused into the medical marketplace, economic stress was put on the profession and the institutions of medicine that could reasonably have been expected to have an inflationary effect. This is exactly what has happened.

Now, however, in an effort to draw attention away from the effect of the programs they support, and to find a more convenient focus for public indignation, proponents of federal health programs are blaming physicians for rising medical care costs.

Among those who are pointing a well-publicized finger at usual and customary charges, and talking about fee schedules, are the administrators of some third-party entities, who have long been involved in the financing of health care through private insurance and prepayment plans and now are involved also in federal funds through their function as agents of the government.

Physicians have the awesome responsibility, first, of recognizing these facts; and, second, of showing their truth to the public.

In addition to whatever can be done on national and state levels by the organizations of medicine, the individual physician can play a vital role in this task.

His most important responsibility will be recognition of the fact that he is the purchasing agent of health and medical care for his patient.

Physicians traditionally have been trained to do their very best for patients by thinking only scientifically and only in terms of results. That must now change. Every physician must now add another responsibility of equal importance.

He must recognize at all times that every decision he makes carries a price tag! If he puts a patient in the hospital, it costs money. If he prescribes, it costs money. If he advises a vacation or retirement, it costs the patient money. Every test, every treatment is a matter of money as well as a matter of science.

The individual physician is in the best possible position, and the only real position, to help his patient make the most of whatever economic resources are available to him—whether they be in the form of cash, insurance, prepayment, or taxes.

It is essential that physicians understand and accept these facts and utilize every opportunity to help patients understand what is being done by the profession to assist them to make most prudent use of their dollars.

Such opportunity certainly is not lacking. Physicians in the United States see 2,225,000 patients every day, which means, statistically, that the total population of this country is seen four times a year.

Physicians Should Give Their Attention to Increasing the Number of Graduates from Medical Schools

Recently, a report was prepared at the AMA comparing certain figures for the medical schools of ten years ago with corresponding data for the same schools today. While the budgets of the schools have risen dramatically, and the size of their faculties has gone up substantially, the output of medical graduates has increased relatively little. In three instances, the number of graduates actually has decreased. In 44 of the schools, the increase in the number of graduates over the ten year period was only five or fewer.

Overall, of course, the number of physician graduates has increased because of larger enrollments in some of the older schools and because of the addition of new schools, a process which is continuing.

However, medical manpower needs for the foreseeable future are not going to be met by present procedures. Innovations in medical education must be developed.

The AMA has an opportunity—indeed, it has an obligation—to call public attention to this very special problem. Only public understanding and the resultant public demand can bring about the necessary changes in present attitudes.

The AMA has been subjected to unfair criticism for having limited the number of physicians, whereas the Association has been doing much to stimulate expansion of physician education through helpful legislation, creation of facilities, and a full-scale careers program. The success of the recruiting efforts is reflected in the fact that twice as many qualified students apply for admission to medical schools as there is room for in those schools. It would seem, therefore, that the next move is up to the schools.

The one thing that has not been done is to put AMA and public pressure on medical faculties and on those responsible for the administration of major universities to the degree that they will respond to the need. We should get on the side of the public more positively in this matter. The benefits of having more physicians are beyond counting. To name only a few, the quality of care would improve because each physician would have fewer patients and more time to spend with each; the convenience of medical care would improve because more physicians would be available when needed; areas that do not now have physicians could be served.

To reach these highly desirable goals, however, requires understanding and effort of our own profession, of the universities and, above all, of the public. There is no one simple answer to how this job can be done. But there are some suggestions that make sense to me. A basic necessity is that administrators and faculties of medical schools return to the concept that the prime mission of the school is the education of medical students so they can practice medicine.

At least partly because of the generous amounts of federal money available for research grants, research, essential and as important as it is, has become as important as teaching to the school as a whole; and more important than teaching to many faculty members. It it not always the fault of the faculty member. Like teachers in other fields, he is a victim of the "publish or perish" syndrome of most colleges and universities. Faculty reputations and advancement are based not on the ability to teach, but on research and its publications.

Research must continue, but it is necessary that it be placed in a more balanced position in medical schools and that major financing arrangements permit such a change. Recent policy positions adopted by the American Medical Association at its Clinical Convention could assist in influencing such a shift in the relationship between teaching and research in medical schools.

It takes relatively few brilliant researchers, with good facilities and financing, to turn out fresh new ideas which can be adapted to the teaching of students. While fewer papers might be published, it is reasonable to expect that those of real and significant content would continue to be produced.

Another suggestion is that medical faculties utilize the facilities of the school more around the clock and around the calendar. There seems to be no good reason, except for tradition, why medical school must consist of four years of eight months each when a total term of three years of 11 months each would afford just as much education and would save a year of the life of both the student and his faculty.

Another aspect of better utilizing facilities would be the greater use of laboratories. The bottleneck in medical education comes in what is now the

first two years, in the teaching of such subjects as anatomy, physiology, and pathology. But consider this possibility: a school with 100 students now could put them into the laboratories from 8 A.M. until noon and then dismiss them. A crew would put the labs back in order for another 100 students from 2 to 6 P.M. under another set of teachers.

A school could double its student body without increasing its facilities. The only significant additional expense would be another set of instructors, assistant professors, and associate professors. Doubling or tripling the salaries of these younger faculty members would attract good ones into teaching and keep them there, and would prove a great deal more economical in the long run than building another entire school, equipping it, and seeing it raid existing facilities to create its own teaching staff.

The clinical years of teaching could be made more efficient by utilizing more hospitals in the cities where medical schools are located. Modern transportation makes this easily possible; and such a program not only would make more beds available for teaching but also would upgrade the services available to patients in those hospitals.

In these and other ways, more medical graduates could be turned out, beginning very soon. But, before it can be done, there has to be acceptance by medical faculties that such procedures are necessary and in the public interest. It is up to the medical profession and the public to stimulate that acceptance.

Every Physician Should Make Himself a Part of the Solution to Problems Affecting His Profession

One cause of justifiable concern to the medical profession is the physician who considers himself so busy with his day-to-day work that he has no time for any of the activities of organized medicine, which he seems to think of as extracurricular.

His feeling, too often, seems to be that he will go along the way he wants because nothing is going to happen in his lifetime, or that he will let somebody else worry about what happens. Such a man is more of a problem to the profession than the one who is called a radical because of his strenuous activities either at the far right or the far left. At least, the man who definitely is at the right or left, and working at it, is well-informed and knows precisely why he stands where he is. The ones that cause more worry are those in the middle who have no convictions, who are not aware of the ramifications of the problem and appear not to care.

Often, when something does go wrong, when a bill is passed that is detrimental to physicians, when a regulation puts uncomfortable restrictions on the profession, these are the men who scream the loudest and demand to know why something was not done to stop that from happening!

It is time for everyone to be concerned about what is happening, and to try to do something about it. If a desire for the betterment of the entire profession is not sufficient motivation, certainly self-interest alone should be reason enough for action.

Medicine Could Well Gain by Observing the Struggle Others are Making to Establish and Maintain a Position

Consider the optometrists. They are having a relatively rough time, but they are highly organized and are making much of every opportunity. Their views are strongly felt in their communities, among their legislators and among their patients. Why? The answer in one state is that dues to the optometric society are about $100 per month. In at least one state, the budget of the optometrists is greater than the budget of the state medical society.

With organization, money and—most particularly—individual activity, chiropractors have made themselves felt to the point that the Senate of the United States attempted to include them in national health legislation in spite of opposition from many distinguished sources.

Osteopaths are a small group and appear to be struggling for their very existence. Yet the contribution to osteopathic education of the average osteopath is four or five times as great as the contribution of the average physician to medical education.

It is time for physicians to re-examine two aspects of what they give to help their profession. One is financial. More important is what they give of themselves to design and carry out the programs of those organizations.

The medical profession is not without resources or talent. But those resources and talents are not presently deployed as they should be in order to face confidently the complicated situations of the day, and to influence effectively the public attitudes and public opinion without which the profession cannot succeed in its efforts to protect its patients and itself.

The Role of Extended Care Facilities, Nursing Homes and Personal Care Homes in the Care of the Chronically Ill

RAYMOND T. BENACK, MD
President, Maryland Association of Nursing Home Physicians

The concept of Nursing Homes and Extended Care Facilities has only been introduced into the general medical philosophy of long-term patient care during the current century. Fifty years ago Nursing Homes of any type did not exist. Even 30 years ago most of those homes which were called "Nursing Homes" provided mainly custodial care with minimal nursing care and little or no medical supervision. As with many other things, World War II brought about a change in some of the basic care patterns of our elderly citizens. Prior to that war, many patients with chronic illnesses received care in their homes by their family or relatives. Even today many families continue to provide such care in their homes. However, a trend developed after the second World War to place in Nursing Homes more of the chronically ill, particularly the elderly individual who required a significant amount of nursing care, or the senile, who required increased assistance in everyday activities or continuous supervision. The advances of modern medicine have amplified the problems by extending the life of the elderly individual. In some instances with the extension of life there has been some improvement in the capacities of the individual, but more often it has just prolonged chronic illness.

During the past 20 years nursing homes progressed from those which provided simple personal care to homes which provided regular nursing care with some medical supervision. The extent of nursing care provided was greater than that which had existed previously but still was significantly less than that provided in the acute hospital. The attitude of many physicians and relatives was that the nursing home was a place to send the chronically ill after all else had failed and where only terminal care was necessary.

This erroneous concept prevented the nursing home from being adequately used as an institution where definitive medical care could be provided. It also prevented the admission to nursing homes of any patients except those who were terminal.

The obvious result of this philosophy was that many patients with chronic illnesses or who required prolonged periods of convalescence or rehabilitation were kept in acute hospitals until their condition was improved to a level where they could return home with minimal nursing care. Many patients with strokes, chronic heart conditions, fractured hips, and even cancer were kept in the acute hospital for long periods of time, either until they recovered, or expired from their illness. Many acute hospital beds were unnecessarily occupied by these chronically ill patients causing a reduction of the available acute beds.

Passage of the Medicare Act introduced a new philosophy into long-term care programs. For the first time a new level of care was proposed which would be incorporated into the continuing care of the chronically ill. This new level of care would be provided in an *Extended Care Facility*. The extended care facility would not be a permanent place of residence but only a step in a total care program for the chronically ill who had been recently hospitalized or for someone with an acute illness which required a significant or protracted period of convalescence or rehabilitation. Patients would not remain in the extended care facility indefinitely but after a period of time, during which they would receive skilled nursing care and physical therapy, they might return to their own home, or be transferred to another facility or a portion of that facility or institution which provided only long-term care or personal care. In order to stress the philosophy of the extended care facility as only a phase in the care program, rather than a permanent place, the Medicare Law limited the extended care facility benefits to 100 days. Granted that many patients might need a level of care equivalent to that provided in the extended care facility indefinitely, or for a period greater than 100 days, it was felt that within this period of time enough therapy would have been provided so that a decision on the future needs of the patient could be made.

The flow of the patient has changed from the acute hospital directly to his own home, or to a long-term care nursing home. The patient will now go from the hospital to the extended care facility and then to the long-term care nursing home or to his own home.

The philosophy of the Medicare Law and the development of the extended care facility was good, but the actual operation of such a program became very complicated. There was almost a complete absence of those facilities which could be classified as extended care facilities. Nearly all nursing homes which were in existence, even the most modern, had not been developed to the level expected of an extended care facility. Many hospitals did not have, nor plan to develop extended care facilities. Therefore, a great deal of dependence was placed on existing nursing homes to be developed into extended care facilities. In order to accomplish this many things had to be done. Not only did the nursing homes have to increase their professional staff or add other services such as physical therapy, occupational therapy, but also they had to develop new patient care policies, transfer agreements, and utilization review programs. Furthermore, a massive education program was necessary to convey to the physicians, acute hospitals, nursing homes, the patients and their relatives the true nature and intent of the extended care facilities. Old ideas concerning nursing homes had to be broken down. A new philosophy of the extended care facility had to be conveyed to the public and to the physicians who practiced in them. Even today, after one year of operation, many people still feel that extended care facilities are nursing homes. Many physicians continue to believe that patients in extended care facilities do not warrant the care required by law, and still consider the type of patient in the extended care facility equivalent to that which was previously cared for in the nursing home.

Another problem in the continuing care of the chronically ill was created by the enlargement of the Medicaid Program. Not only did many patients in nursing homes and extended care facilities

become eligible for care under this program but also many nursing homes not previously classified as extended care facilities were required to upgrade their standards to be eligible for the program. Therefore, not only did the extended care facilities have to be developed, but also many nursing homes had to be upgraded to provide care for the rapidly enlarging population of chronically ill patients who required skilled nursing care.

Furthermore, many patients who were admitted to extended care facilities under Title 18 ultimately became beneficiaries of Nursing Home Benefits under Title 19. Often they did not move to another facility, but continued to occupy the same bed. There was a gradual decrease in available extended care facility beds and many extended care facilities began to provide long-term skilled nursing care. This new problem must be resolved through the determination for each patient the level of care he will require based upon his physical limitations and the nature and extent of his illness.

There now has developed over the years approximately three different levels of care for the post-hospital or chronically ill patient who can no longer be cared for in his own home. These three levels of care include: Extended Care, Long-Term Care and Personal Care. We can no longer use the term "Custodial Care" since it is too general. Over the years "Custodial Care" has come to mean that level of care provided to the chronically ill, which was necessary to prevent unnecessary deterioration of the patient's condition. This philosophy is false because the maintenance of health with regular nursing care is not "Custodial Care" since it requires an active participation on the part of the Medical and Nursing Staff to maintain the patient's state of health. "Custodial Care" could not easily be provided to those patients who needed only assistance in the maintenance of their daily activities since this was significantly less than what was implied by tradition as "Custodial Care." Actually those who require simple assistance in their daily activities received "Personal Care." Therefore, it would be best to completely eliminate the term "Custodial Care" from our current philosophies and use those terms which more specifically define the level of care provided.

The new terms would be: Extended Care, implying that this is an extension of hospital care, and is intended to be short-term, which at the present is limited by the law to 100 days; Long-Term Care, would be for periods greater than 100 days and could include the level of care provided under Extended Care, but also would include skilled nursing care at a slightly less intensive level. This would include those patients who require regular nursing supervision and definite nursing care, and not just simple administration of drugs or assistance in performing everyday activities; Personal Care might be considered similar to the Home for the Aged or domiciliary care, since it provides only assistance in the performance of everyday activities, insuring a proper diet or giving of medication, which the patient might have taken himself, but because of the nature of his illness or because of senility he could not do or might forget to do. There is no active nursing care provided at this level of care.

At each level of care there is an equal degree of medical supervision. The patient who is receiving extended care would require regular medical supervision at frequent intervals, which should be no less frequent than once a month and preferably at least once a week. The long-term care patient also requires regular supervision but not as frequently as the extended care patient. This could be as frequent as once a month, but in some instances, depending on the nature and extent of the patient's illness, might be more frequent. The personal care patient requires no regular medical supervision other than that which he might have received at home and would be seen with the frequency indicated by his condition and the interest of the physician.

These levels of care and the facilities providing them, and the insurance of a steady flow of patients from the acute hospitals, is dependent upon the existence of a firm foundation of home health services. Obviously all patients with chronic illnesses or protracted illnesses could not be sent to one or the other type of facility since there are not enough facilities to accommodate all these patients. There is a significant lack of personal care homes and therefore a great deal of dependence must be placed on the development and implementation of home health services. Without these services the whole program could not function smoothly. Home health services obviously would provide to the patient in his private home those services which are needed infrequently, but with some degree of regularity to help the patient become self-sufficient. Often it may be the simple checking by a nurse or regular visits by a Physical Therapist, or daytime

assistance in preparation of meals. Only with such services available could many patients be returned home. Without such services the physician could not plan for any level of care other than the lowest level available, which is most compatible with his condition. With the lack of home health services and personal care homes, most patients would remain in a long-term care facility. Since the cost of maintaining a patient in a long-term care facility would be significantly greater than home care, the problem of expense becomes a major factor.

Each level of care is necessary. There must be available facilities able to accommodate each type of patient. One institution may provide different levels of care, or there may be different institutions providing different levels of care. We are, however, faced with the need for all levels of care, and facilities to accommodate each. We also need home health services to supplement the nursing home and extended care facilities. Without these home health services we are faced with a major problem of economics in providing care for patients who receive a level of care higher than they actually need.

We need the extended care facilities to provide intensive rehabilitation and intensive skilled nursing care to the recently hospitalized patient so that the acute hospital beds may be relieved of the long-term care patients. We need the long-term care facility to accommodate those patients whose illness requires indefinite skilled nursing care or a prolonged period of rehabilitation. Without these facilities the extended care facilities will become over-loaded with long-term care patients. We need the personal care facilities to accommodate those patients who have need only for assistance in the performance of their everyday activities and who do not require skilled nursing care. Without these facilities our long-term care facilities will become over-loaded with patients. Also, we need home health services to supplement all these services so that more patients might return to their homes and not be left in extended care facilities or nursing homes for an indefinite period of time.

In conclusion, we might state that there is necessary three levels of care for the post-hospital patient. Actually these levels of care can be applied to all patients who have a chronic illness or who require a prolonged period of convalescence or rehabilitation. The extended care facility which provides skilled nursing care and intensive medical supervision; the long-term care facility provides skilled nursing care and regular medical supervision for an indefinite period of time, and the personal care facility, which provides only assistance in everyday activities with no regular nursing care and without any regular medical supervision. To supplement all of these, a well-developed program of home health services is necessary.

Ultimately it will be dependent upon physicians to determine which level of care their patients require, and the period that care will be necessary. It will depend upon their effective use of each facility providing this type of care, and it will depend on their regular evaluation of the patient's needs. It will depend upon the physician to see his patient frequently and regularly in the extended care facility, to see them less frequently but still regularly in long-term care facilities and to insure that the patient in the personal care home is seen no less frequently than the patient he sees in his office or in their own home.

It will depend upon the physician to judiciously use the home health services to supplement the institutional care and it will be dependent upon the community to develop these institutions and home health services necessary to provide these levels of care.



your medical faculty at work

by John Sargeant
Executive Secretary

The Council on June 6, 1968 met and took the following actions:

1. Formally acknowledged the receipt of an oil portrait of Albert E. Goldstein, MD, past-president of the Faculty.
2. Formally acknowledged the retirement of two members of the Board of Medical Examiners and authorized letters of appreciation for the services of Walter C. Merkel, MD, from 1956-1968; and Wilber R. Ellis, MD, from 1962-1968.
3. Heard of disposition of various physicians' defense cases.
4. Ratified legal defense for certain other physicians.
5. Adopted minutes of the Council for April 17 and 19; and of the Executive Committee for May 9.
6. Agreed to recommend Emeritus Membership to the House of Delegates for certain members as requested by their component societies.
7. Approved the financial statement and dedicated fund statement through March 31, 1968.
8. Authorized expenditure of funds beyond receipts from insurance coverage to replace 10 electric typewriters and two calculators stolen in a burglary at the Faculty building.
9. Authorized installation of a burglar alarm system in the Faculty building.
10. Authorized legal counsel to proceed with the legal work necessary to obtain an injunction to prohibit the use of the term "physician" by Chiropractors basing this action on an Attorney-General's opinion that the use of such term is improper and illegal.
11. Authorized legal counsel to pursue the question of "testing" techniques used by Chiropractors who mislead the public by indicating their ability to diagnosis diseases.
12. Requested legal counsel to prepare certain amendments for submission to the House of Delegates at the Semiannual Session in connection with the proposed revision of the Medical Practice Act.
13. Heard a report from the Special Liaison Committee with the State Health Department in regard to a meeting with the Ad Hoc Health Planning Committee appointed by the Governor.
14. Approved a recommendation that the newly formed State Airport Authority be approached and urged to make provisions for adequate medical coverage at Friendship Airport.
15. Endorsed annual Diabetes Detection Drives, subject to approval on the local level by heads of component societies who would be free to implement these when they see fit.
16. Adopted Guidelines for Hospital Staffs for the Performance of Therapeutic Abortions; and approved directing a letter to the State Board of Health and Mental Hygiene offering the services of the Faculty in connection with the implementation of the abortion law, such as developing a form for hospital reporting—on an annual basis—of all therapeutic abortions; and authorized the Subcommittee on Maternal Welfare to act as such an Advisory Committee, if the Board so wishes one.

17. Voted to table a recommendation that Cancer Workshops and Cancer Detection Centers in community hospitals be established until such time as more information is available and this suggestion is clarified.
18. Voted to reaffirm Council action of January 25, 1968, wherein cancer registries should be "voluntary."
19. Referred a proposed revised School Examination Form to the Child Welfare Subcommittee for study and a report with recommendations, if any.
20. Authorized legal counsel to investigate authority for IRS to establish a 39% tax deductibility for the 1966 cruise convention of the Faculty; and also authorized a formal request to IRS for a specific ruling on the 1968 cruise convention.
21. Heard that a public hearing has been set for September 12 and 13 on HJR 41, requesting the Consumer Protection Division of the Attorney-General's office and the Faculty to investigate the "promiscuous" dispensing of diet pills and recommend any legislation to control such practice.
22. Declined to take any action on an indirect request for a list of names for appointment to the Blue Shield Board of Trustees of the Chesapeake Bay Foundation.
23. Voted unanimously to submit the name of Claude D. Hill, MD, Baltimore, to the Blue Shield Board of Trustees for possible election to that Board to replace C. Parke Scarborough, Jr., MD, who died recently.
24. Authorized the Chairman of the Professional Medical Services Committee to designate a nominee to the State Health Department for a special committee being set up to "develop a form to serve several purposes related to long-term care facilities."
25. Agreed to leave the question of direct specialty representation in the AMA House to the discretion of the Faculty's delegates to the AMA House of Delegates.
26. Approved submission of various names for possible appointment to various AMA Committees and Councils.
27. Referred the question of whether or not dentists should be trained in the taking of throat cultures to the Child Welfare Subcommittee. This question was raised by the Maryland State Dental Association.
28. Heard a report from the Library Committee in regard to the current study under way in connection with the Library collection.
29. Approved the principle of a Formulary System for physicians to use in prescribing for Medicaid patients, with the understanding that this is to be an "open" formulary, and that it will be developed with full cooperation of the Faculty.
30. Heard a brief report in connection with activities of the Regional Medical Programs; and nominated Paul F. Guerin, MD, to serve as Faculty representative to the Advisory Council on RMP, succeeding William A. Pillsbury, MD, who resigned because of the press of other responsibilities.
31. Authorized Russell S. Fisher, MD, to serve as Faculty representative on the newly formed Medical Tissue Donation Committee.
32. Heard a summary of recent activities of the Blue Cross Board; and authorized notification of Faculty designees to both Blue Cross and Blue Shield Boards that they "extend every effort in attempting to have both plans become the disbursing agent for the Medicaid program in Maryland."

STATE OF MARYLAND
DEPARTMENT OF MENTAL HYGIENE

Isadore Tuerk, MD, Commissioner Kurt Gorwitz, ScD, Statistics Director

Maryland's Mental Hospitals Five Years After Desegregation

Admissions to Maryland's four major mental hospitals were for the first time placed on a regional basis in January, 1963. Since that time, the majority of all patients admitted to each of these facilities have been white. However, this desegregation plan did not provide for the transfer of patients already in residence. Since many of these continue to be hospitalized, integration has been gradual and concentrated primarily in the short-term active treatment areas. Latest available data (as of December 31, 1967) indicate that 60.9 % of all nonwhite patients and 9.2% of all white patients are at Crownsville. The comparable figures for those admitted since January, 1963 are 32.2 and 19.1%, respectively.

PERCENT OF PATIENTS IN EACH HOSPITAL NONWHITE

Date	Total	Crownsville	Eastern Shore	Springfield	Spring Grove
DEC. 31, 1962	22.6	100.0	0.0	0.0	0.0
DEC. 31, 1963	23.4	85.9	7.6	6.2	4.5
DEC. 31, 1964	23.9	78.2	10.7	8.9	7.1
DEC. 31, 1965	24.9	73.4	14.9	11.5	8.9
DEC. 31, 1966	25.5	71.0	16.6	13.2	9.9
DEC. 31, 1967	25.6	69.4	18.2	14.3	9.8

Prior to this change in policy, white admissions had in effect been on a regional basis (to three hospitals) while nonwhite admissions had been limited to one facility (Crownsville). The revision thus brought mental hospitals considerably closer to some segments of the nonwhite population. As a result, although both the number of white and nonwhite admissions have continued to increase, the latter figure has been rising at a faster pace. Latest available data (for the year ending June 30, 1967) indicate that 28.3% of all patients admitted to the above facilities were nonwhite as compared with the 26.2% reported five years earlier. However, this change has been selective and concentrated among the nonpsychotic. For example, among patients admitted for psychoneurotic and personality disorders the nonwhite percent increased from 20.8 to 29.5 during this time period.

Proportionally, nonwhite admissions to the state hospitals have continued to be twice as frequent as white. In part, this is related to the concentration of nearly half of all Maryland Negroes but less than 10% of the state's white residents in Baltimore's inner core slum areas where rates of most types of treated mental illnesses and of other public health problems are substantially above average. In part, also, this reflects the much greater use of alternative psychiatric services (particularly in privately operated hospitals and in private practice) by the white middle class. Since state hospitals are only one of a variety of psychiatric resources available to the community, desegregation of these facilities by itself cannot necessarily be expected to provide the opportunity for adequate care to meet the needs of all population segments. That is, programs to meet these issues and problems must involve all available resources and services and cannot be limited to state operated facilities alone.

REHABILITATION NOTES

Douglas Carroll, MD, Editor

Measurement of Performance in Rehabilitation*

"In hospital jargon, 'diseases' are 'morbid entities,' and medical students fondly believe that these 'entities' somehow exist *in rebus Naturae* and were discovered by their teachers much as was America by Columbus.

Teachers of Medicine, on the other hand, seem to share the implied belief that all known, or knowable, clinical phenomena are resumable, and to be resumed, under a certain number of categories or general references, as so many 'diseases'; the true number of these categories, references, or 'diseases' being predetermined by the constitution of the universe at any given moment.

In fact, for these gentlemen, 'diseases' are Platonic realities: Universals *ante rem*. This unavowed belief, which might be condoned were it frankly admitted, is an inheritance from Galen, and carries with it the corollary that our notions concerning this, that, or the other 'disease' are either absolutely right or absolutely wrong, and are not merely matters of mental convenience. In this way, the diseases supposed to be extant at any one moment are capable—so it is thought—of such categorical exhaustion as are the indigenous fauna of the British Isles and the population of London. That our grouping of like cases as cases of the same disease is purely a matter of justification and convenience, liable at any moment to supersession or adjustment, is nowhere admitted; and the hope is held out that one day we shall know all the diseases that there 'are,' and all about them that is to be known."

DIAGNOSIS

In attempting to predict whether a patient will improve under treatment in a Department of Physical Medicine and Rehabilitation, a number of factors must be taken into consideration. The most important factor is the medical situation and its prognosis, but the degree of physical and mental impairment, motivation and social aspects all play a part.

The following system is now being used. It is an attempt to refine the diagnostic rubric by modifiers in a shorthand which will help identify the important factors in prognosis for independence in activities of daily living (ADL).

Although a good prognosis for life is generally related to a good prognosis for improvement in physical independence, there are exceptions. A patient who has undergone a craniotomy and has been found to have an inoperable malignant brain tumor has a poor long-term prognosis for life. He may, however, have an excellent short-term prognosis for improved physical function and may even return to normal activities for a prolonged period. Thus, prognosis for significant activity rather than prognosis for life is one immediate concern.

Two different aspects of the patient's illness have been developed to make the diagnosis more precise in term of functional prognosis: 1. A list of the most frequent diagnoses (Table I) for which patients are referred to the Department of Physical Medicine and Rehabilitation has been compiled. These "diagnoses" consist of etiological entities (tuberculosis, burns), syndromes (hemiplegia, "chronic brain syndrome"), anatomical terms (upper and lower extremities, vertebral column) and impairments (blind). Nearly all of these diagnoses are associated with some impairment amenable to treatment in a Department of Physical Medicine and Rehabilitation. If a patient has

* This is the third in a series of notes on "Rehabilitation of Chronic Impairments in Adults."

more than one of the conditions listed, he is considered to have more than one diagnosis. The list in Table I includes only those diseases for which the patient was referred to the Department of Physical Medicine and Rehabilitation. The disease causing referral to the Department of Physical Medicine and Rehabilitation may not be the same disease causing admission to the hospital. A large number of diagnoses, therefore, are not included in Table 1. Each diagnosis is numbered. Beside each diagnosis, one or more of the following symbols is placed.

M—"Major disabling diagnosis": This diagnosis (constellation of symptoms, signs and laboratory findings) is the major cause of admission to the hospital. It is the diagnosis that made hospitalization necessary at this time. (It is not necessarily listed in Table 1)

P—Major diagnoses causing referral to the Department of Physical Medicine and Rehabilitation. (These diagnoses are listed in Table 1)

E—"Existing": A disease which is neither the major cause of admission nor of referral to the Department of Physical Medicine and Rehabilitation, but is pathologically active or causes impairment in performance at the time of initial evaluation in the Department of Physical Medicine and Rehabilitation.

N—"Non-contributory": A disease discovered and/or treated in the course of investigation, but not giving rise to symptoms or impairment in performance at the time of initial evaluation in the Department of Physical Medicine and Rehabilitation.

O—"Old": Part of previous history. May be associated with E or N.

Some of the possible examples follow:

Example A. 1. MP Cerebrovascular accident with left hemiplegia.

Example B. 1. MP Cerebrovascular accident with left hemiplegia.
2. N Benign prostatic hypertrophy (asymptomatic)

Example C. 1. MP Subcapsular Fracture left hip. Austin-Moore Prosthesis.
2. NO Cerebrovascular accident with left hemiplegia (transient).

Example D. 1. M Arteriosclerotic Heart Disease with Acute Myocardial Infarction.
2. PE Cerebrovascular accident with left hemiplegia.

The above patients all had diagnoses of cerebrovascular accident with left hemiplegia. Yet their prognoses both for life and for return of function are entirely different. In recording the diagnoses, the above-mentioned symbols allow more precise identification of prognosis. The above symbols placed beside each diagnosis allows identification of the reasons for hospital admission, for referral to the Department of Physical Medicine and Rehabilitation, presence of associated diseases, and the importance of secondary diagnoses in causing symptoms.

The patients have been divided into three groups depending on the number of diseases present. The purpose of this system is to allow comparison of patients with the same diagnosis.

Diagnostic Group 1: Patients with one and only one disease, injury or manifestation. An example (with the symbol of its importance in causing hospitalization and referral to the Department of Physical Medicine and Rehabilitation) is Example A above. Such patients have the same reason for admission and for referral to the Department of Physical Medicine and Rehabilitation (MP).

Diagnostic Group 2: Patients with one manifest disease only, but with associated unmanifested (picked up by history, physical or laboratory examination) diseases.

These patients may have more than one disease, but the secondary diseases do not obviously interfere with physical performance. Although the associated unmanifested diseases may make the prognosis for life shorter, they are not expected to interfere substantially with return of physical function while the patients are undergoing rehabilitation. When the patient is first seen in the Department of Physical Medicine and Rehabilitation, one is concerned with whether or not he can show improvement in function within several months. The physical function in the distant future is not of primary importance. Such patients have the same reason for hospital admission and referral (MP) but in addition many have a number of unmanifested diseases (N). Examples B and C (above) are instances of Diagnostic Group 2.

Diagnostic Group 3: Patients not fitting into Diagnostic Group 1 or 2.

This group contains all patients with multiple diseases causing manifest reduction in function (example D).

"Chronic Brain Syndrome" or any other syn-

drome or diagnosis associated with disorientation, poor memory or inability to follow directions is not included in this diagnostic system because it is given a separate category as the third major area of evaluation, which will be considered later.

A second method for making the diagnosis more precise for purposes of estimating prognosis for function is the use of categories having to do with suddenness of onset of symptoms, duration of symptoms and prognosis for life. On each patient the suddenness of onset and the duration of the disease *bringing the patient to the Department of Physical Medicine and Rehabilitation* is recorded. In addition, the estimated prognosis for life for the patient, *taking all factors into consideration,* is recorded.

TABLE 1

Major Diagnosis, Syndromes of Impairment Causing Referral to Department of Physical Medicine and Rehabilitation

I. *MECHANICAL* (Musculo-skeletal-orthopedic)

A. Lower Extremity and Pelvis (other than below)
1. Fracture
   a) Pelvis
   b) Leg
   c) Hip
2. Contracture
3. Infection
4. Amputation
5. Nerve Injury (includes intervertebral disc)
6. Dislocation
7. Tendon Injury
8. Ulcer
9. Arterial Insufficiency
10. Congenital Anomaly
11. Bursitis
12. Prosthesis (Austin-Moore)
13. Tenosynovitis
14. Pain of Unexplained Origin
15. Ruptured Meniscus
16. Multiple Injuries of Bone, Tendons, Veins, Arteries
17. Aseptic Necrosis Hip
18. Corrective Orthopedic Surgery
19. Laceration

B. Upper Extremity (other than below)
1. Fracture
2. Contracture
3. Infection
4. Amputation
5. Nerve Injury (includes intervertebral disc)
6. Dislocation
7. Tendon Injury
8. Ulcer
9. Arterial Insufficiency
10. Congenital Anomaly
11. Bursitis
12. Prosthesis
13. Tenosynovitis
14. Pain of Unexplained Origin
15. Shoulder-Hand
16. Multiple Injuries of Bone, Tendons, Nerves, Arteries
17. Carpal Tunnel Syndrome

C. Vertebral Column (not involving spinal cord)
1. Fracture, Traumatic
2. Infection
3. Dislocation
4. Congenital Deformity
5. Pain of Unexplained Origin
6. Intervertebral Disc Disease without Neurological Involvement
7. Scoliosis
8. Metastases
9. Osteoporosis and Collapse of Vertebrae

D. Arthritis and Connective Tissue Disease (other than below)
1. Rheumatoid Arthritis
2. Scleroderma
3. Rheumatoid Spondylitis
4. Systemic Lupus Erythematosis
5. Gout
6. Osteoarthritis
7. Septic Arthritis
8. Tuberculous Arthritis
9. Unclassifiable Connective Tissue Diseases

E. Skin
1. Burns
2. Dermatitis

II. *MOTOR* (Efferent Neurological)

A. Neurological (other than below)
1. Cerebral Palsy
2. Epilepsy
3. Parkinson's Disease
4. Cranial Nerves
5. Neoplasm
6. Disseminated Sclerosis
7. Quadraplegia
8. Paraplegia
9. Poliomyelitis
10. Peripheral Neuritis
11. Myositis or Muscle Disease
12. Infection
13. Wernicke's Encephalomyelitis
14. Amyotrophic Lateral Sclerosis
15. Pernicious Anemia with Acute Combined Sclerosis

B. Cerebrovascular (other than below)
1. Cerebral Infarction(s) due to vascular disease other than below
2. Cerebral Infarction with Right Hemiplegia (thrombosis, embolus or hemorrhage)
3. Cerebral Infarction with Left Hemiplegia (same as 2)
4. Subarachnoid Hemorrhage
5. Subdural Hematoma
6. Trauma to C-V Vessels

III. *SENSORY* (Afferent Neurological)

A. Cerebellar
B. Cortical Sensory
C. Cord
D. Blind

IV. *FAILURE OF A SYSTEM*, with generalized weakness and/or debility

A. Cardiac
B. Coronary
C. Respiratory
D. Renal (uremia)
E. Hepatic
F. Gastrointestinal
G. Endocrine
H. Metabolic—Obesity
I. Neoplasm other than CNS
J. Tuberculosis
K. Post-Operative
L. Multiple Diseases
M. Chronic Brain Syndrome
N. Depression
O. Other Psychiatric

V. *MISCELLANEOUS* (cannot be classified as one of the above)

ALCOHOLISM SECTION

The Family Physician and Alcoholism

MICHAEL SHENKMAN, MD
Bergen County, New Jersey

The American Medical Association in 1956 recognized alcoholism as a disease. The National Council on Alcoholism, the voluntary health agency in the field of alcoholism, has regarded alcoholism as a disease for two decades. These pronouncements have helped to gain greater recognition and acceptance of the problem, but there are still too few family physicians who are willing to take an active part in the rehabilitation of their alcoholic patients.

A clearer understanding of the role of the family physician may help to remedy this situation. This role is a strategic one in the identification and motivation of the alcoholic. Quite frequently, the early stage or incipient alcoholic seeks medical attention for such things as "nervousness," "gastric upset," "sleeplessness," or any number of symptomatic complaints. Repeated visits for medication for such vague or varying complaints should alert the physician to suspect alcoholism. The next step is to discuss these suspicions openly and frankly with the patient. Once the physician becomes convinced that his patient is alcoholic, the very fact that he, as a physician, makes the diagnosis gives him a far better chance to penetrate the patient's denial and to gain his cooperation. The alcoholic's wife, despite her long and troubled awareness of his growing incapacity to function as a husband and breadwinner, is handicapped precisely because her role is that of a wife and not a therapist.

If the physician's understanding of alcoholism enables him to approach alcoholism both as an objective scientist and as a compassionate therapist, this will create an uniquely effective impact. And such an impact is needed to overcome the condemnation still implicit in this diagnosis, as well as the deep and controlling dependence upon alcohol.

Resources and their Use

It is not suggested that the family physician can begin to provide all of the resources for the alcoholic's rehabilitation. However, he can enlist and coordinate the available resources in the community just as he would if the patient suffered from any illness requiring a series of treatment measures. As regards these resources, many physicians may not be aware that today there are available in most communities a variety of helping agents and agencies that can meet many of the alcoholic's needs.

Gains have also been made in obtaining some acceptance and understanding of alcohol problems among family service agencies, mental health clinics, pastoral counselors, and vocational rehabilitation offices.

Dr. Shenkman is Chairman, Committee on Alcoholism, Bergen County Medical Society, New Jersey.

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With regard to the use of outside resources, the patient will need sufficient preparation for referral so that he can regard this step as a demonstration of the physician's continuing concern for him and not as a rejection of him. It goes without saying that each referral requires not only an understanding of the policies and program of the particular resource but sufficient explanation to the patient so that he will know just what kind of help to expect. Once a referral has "taken," the physician will want to be kept informed of the patient's progress so as to be able to suggest any further help which may be indicated.

The Family's Role and Needs

The cooperation of the patient's family may be crucial in supporting the rehabilitation process. They need to understand how alcoholism begins and develops, to be aware that the alcoholic suffers from an illness, to be reassured that help is available and that rehabilitation is possible. Often the wife is tense and anxious, and because of the many hardships she has suffered can give the alcoholic little sympathy. Before we can expect her really to be able to support his recovery we must be prepared to understand and support her struggle to keep herself and her family intact. The teenaged children of alcoholics have been found to be especially in need of guidance. The help they receive will enable them to contribute to the alcoholic's recovery, but will be even more essential for their own welfare. Help for the families of alcoholics is available at the Alcoholism Treatment Centers, the National Council on Alcoholism . . ., the growing number of Al-Anon groups and more recently developed Alateen groups . . . family members are also helped by family service agencies, guidance centers, and other mental health and counselling resources.

Why the Doctor Can Make a Difference

I am not suggesting that the family physician undertake long-term therapy with the alcoholics in his practice, but that he should be aware of those physicians, groups, and agencies in the community who are equipped to provide this service. He can play a strategic role in identifying the early alcoholic and in helping him to acknowledge and to do something about his illness. Moreover, the physician can offer continuing supportive therapy and is in a position to be the key person in coordinating and sustaining rehabilitation. This can be especially valuable because alcoholism is a chronic illness, and as such, relapses may well occur in the course of rehabilitation.

Acceptance of this fact will not only lessen the physician's discouragement when "slips" do occur, but enable him to provide the kind of unwavering relationship which can be used to turn such setbacks to good effect. In short, the family physician has the potential for being the essential catalyst for his alcoholic patients in initiating and sustaining the process of their recovery.

Ethics Corner

Complaints have been filed with the Faculty office in connection with bills submitted by physicians to their patients. At a subsequent date, a service report is received by the insurance carrier indicating a higher fee than was billed to the patient.

The patient complains because of the difference in the fees and assumes, rightly or wrongly, that the physician is increasing his fee because insurance is involved.

Physicians should not bill different amounts to patients and their insurers for the same services. *The physician's fee should be consistent whether there is insurance involved or not.*

If the physician wishes to reduce his fee because of the financial circumstances of the patient, this should be indicated on the original billing to the patient.

BALTIMORE CITY HEALTH DEPARTMENT

Robert E. Farber, MD, MPH, Commissioner

Infant Immunization Report

Since June 1965, the Baltimore City Health Department has received federal project grant funds to support an ongoing program designed to promote infant immunization against polio, diphtheria, tetanus, whooping cough, smallpox and measles.

The program is currently producing information which shows that about 15,000 babies under one year of age or 81% of the infant population of Baltimore City are adequately protected against polio, and about 71% have received immunization against diphtheria, tetanus and whooping cough. The Baltimore City Health Department well baby clinics furnished vaccine to about half the infant population.

Special wallet-size plastic immunization-birth record cards are made available to infants born in Baltimore City who complete their baby shots. Parents are notified regarding the record cards through a special mail-out system included in the program. These cards serve not only as a record of dates the inoculations were received, but also as proof of the child's age. The card also includes the birth certificate number.

A vital extension of the program begun in January of this year is a home visit activity for infants who have not been able to receive their immunizations. A small, but ambitious staff of five health aides is working throughout the city to help parents in making the necessary arrangements to protect their children from the diseases for which vaccines are available. Although the health aides are part-time employees, much of their work is completed during off hours when visits to working mothers are more convenient. It is this enthusiasm that is contributing to the success of the program. Plans are also underway to survey all kindergarten children in the public and parochial schools in the fall and to obtain protective inoculations where the child is unprotected or has not completed the particular series of protective shots.

PROGRAM

OCEAN CITY MEETING

MEDICAL AND CHIRURGICAL FACULTY

SEPTEMBER 5, 6, 7, 1968

DIPLOMAT MOTOR HOTEL

THURSDAY, SEPTEMBER 5

8:00 P.M.—House of Delegates Meeting
All members of the Faculty are invited to attend

FRIDAY, SEPTEMBER 6

9:30 A.M.—House of Delegates Meeting
All members of the Faculty are invited to attend

9:30 A.M.—Woman's Auxiliary Meeting

1:00 P.M.—MMPAC Luncheon Meeting
Phillips Crab House

1:00 P.M.—Meeting of Maryland Ophthalmological Society
and Maryland Academy of Ophthalmology

1:30 P.M.—Meeting of Maryland Psychiatric Society

6:30 P.M.—POOLSIDE COCKTAIL PARTY AND BANQUET

SATURDAY, SEPTEMBER 7

9:00 A.M.—Meeting of Maryland Chapter, American College of Surgeons

10:00 A.M.—Meeting of Maryland Society for the Rheumatic
Diseases and Arthritis Foundation

11:00 A.M.—Meeting of Faculty Subcommittee on Diabetes
and Maryland Diabetes Association

1:00 P.M.—CRAB FEAST LUNCHEON
Phillips Crab House

A complete program will be mailed to all members in August and to others upon request.

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Please indicate whether this is satisfactory: YES..... NO.....

HEART PAGE

Jerry Salan, MD, Editor

A Service of the Heart Association of Maryland

Heart Transplantation

JOSEPH S. McLAUGHLIN, MD
Assistant Professor of Surgery,
University of Maryland School of Medicine;
John and Mary R. Markle Scholar in Academic Medicine

In 1904, Carrel and Guthrie transplanted the heart of a small dog into the neck of a larger one. The heart beat for one hour. After many such experiments, Carrel correctly reasoned that the failure of the heart and other organs to function in alien bodies was not surgical, but biologic in origin. This hypothesis was proven four decades later by Medawar, who described biologic rejection and other phenomena of transplanted tissues. Both Carrel and Medawar were awarded the Nobel Prize for their pioneering efforts.

Sporadically, other investigators transplanted human hearts into the neck (heterotopic transplantation) with increasing success, and with the development of cardiopulmonary bypass, transplantation of the heart into the normal anatomical position (orthotopic transplantation) has become a well established laboratory procedure.

Transplantation of parts of the human circulatory system has been successfully carried out since 1948, when Gross used a cadaver aorta as a graft in repairing a resected coarctation of the aorta. This technique was widely utilized to replace aneurysms of the abdominal aorta prior to the development of satisfactory artificial vascular prostheses. In more recent years, Ross and Barrat-Boyes have transplanted cadaver aortic valves into patients with acquired aortic valvular disease with striking initial success. Weldon and Gott have used the aortic root from cadavers to replace the pulmonary artery of patients undergoing correction of Tetrology of Fallot.

Transplantation of the cadaver aorta is successful because this structure is essentially a dead latticework of collagen fibers into which the recipient's tissues grow, isolating it from the rest of the body. The graft performs no biologic function other than to serve as an insulated conduit through which the blood must pass. Although an immune response is initiated and the graft is eventually destroyed, this process is sufficiently slow to allow a new structure to replace it. On the other hand, biologically active tissue encounters a different fate. The body's immune response is activated, and intense inflammation and cellular infiltration of the foreign tissue occur and vascular thrombosis ultimately leads to the rejection of the tissue and death of the host.

Studies performed by Chiba and his associates have demonstrated a similar chain of events in transplanted animal hearts. First signs of inflammation occur within three hours and the histologic picture of cardiac allograft (homograph) rejection is characterized by acute granulomatous carditis and necrosis similar to that seen in rheumatic carditis. The first clinical signs of rejection occur within 48 hours and survival of canine

heart transplants ranges from 4 to 21 days, with an average survival of 7 days. The suppression of this immune response, therefore, is the key to successful transplantation.

A number of measures have been utilized to suppress immunologic response and include total body irradiation and various chemical compounds. Thus far, irradiation and all drugs tested have had the disadvantage of inducing general immunosuppression rather than specific inhibition of allograft rejection, and their use is associated with toxicity and bacterial invasion. Cortisone may be an exception to the above, and prednisone has afforded dramatic improvement in rejection crises associated with human kidney transplants. At present, the most effective immmnosuppressive drug is azathioprine, a relative of 6-mercaptopurine, which has been widely used in human renal allografting. It has few side effects and is effective in doses that do not result in bone marrow depression. R. R. Lower et al, have demonstrated that the use of azathioprine and cortisone prolong transplanted canine heart survival for as long as nine months. Early deaths usually occur from infection, and later deaths from myocardial necrosis.

The first heart transplantation involving a human was performed in 1964 by James D. Hardy, MD, of Jackson, Mississippi. The donor was a chimpanzee whose heart functioned in the human recipient for a short period of time but then failed, probably because of its relatively small size.

On December 3, 1967, Christiaan Barnard, MD, transplanted the heart of a young neurologically dead woman into Louis Washkansky at the Groote Schurr Hospital, Capetown, South Africa. The patient lived 18 days before he succumbed to bilateral pneumonia. Shortly thereafter, A. Kantrowitz, MD, in Brooklyn, performed two human heart transplants; both recipients died within ten hours of the procedure. Sen in Bombay and N. E. Shumway, MD, in Palo Alto, performed more successful transplants. Shumway's patient lived two weeks.

The longest survivor to date is Dr. Philip Blaiberg, a 54-year old dentist, also operated up by Dr. Bernard, who at the time of this writing is six months postoperation.

Thus, one of six patients is alive and initially left the hospital.

Recent events have proven the technical feasibility of human heart transplantation and have demonstrated that the rejection phenomena can be overcome at least temporarily. The moral problem remains and no doubt will be a subject of controversy for some time to come.





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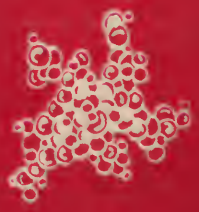
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In trichomonal vaginitis, most physicians have reported a cure-rate of 95 per cent or more with Flagyl when infected male partners are treated concurrently and when treatment is repeated for occasional refractory infections in women.

Among the few patients who do not respond to Flagyl are those who may not have taken the prescribed dosage and those who may have been reinfected.

This high rate of cure obtained with Flagyl is unparalleled. Only systemically active Flagyl reaches the hidden reservoirs of reinfection in male and female genitourinary tracts.

Indications: Flagyl is indicated only in the treatment of trichomoniasis in both the male and female.

Contraindications: Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution: Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side effects: Infrequent and minor side effects include nausea, metallic taste and furry tongue. Gastrointestinal disturbances, flushing and headache sometimes occur, especially with concomitant ingestion of alcohol. The taste of alcoholic beverages may be altered. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness or paresthesia of an extremity, joint pains, confusion, irritability, weakness, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

Dosage and Administration: In women: one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.

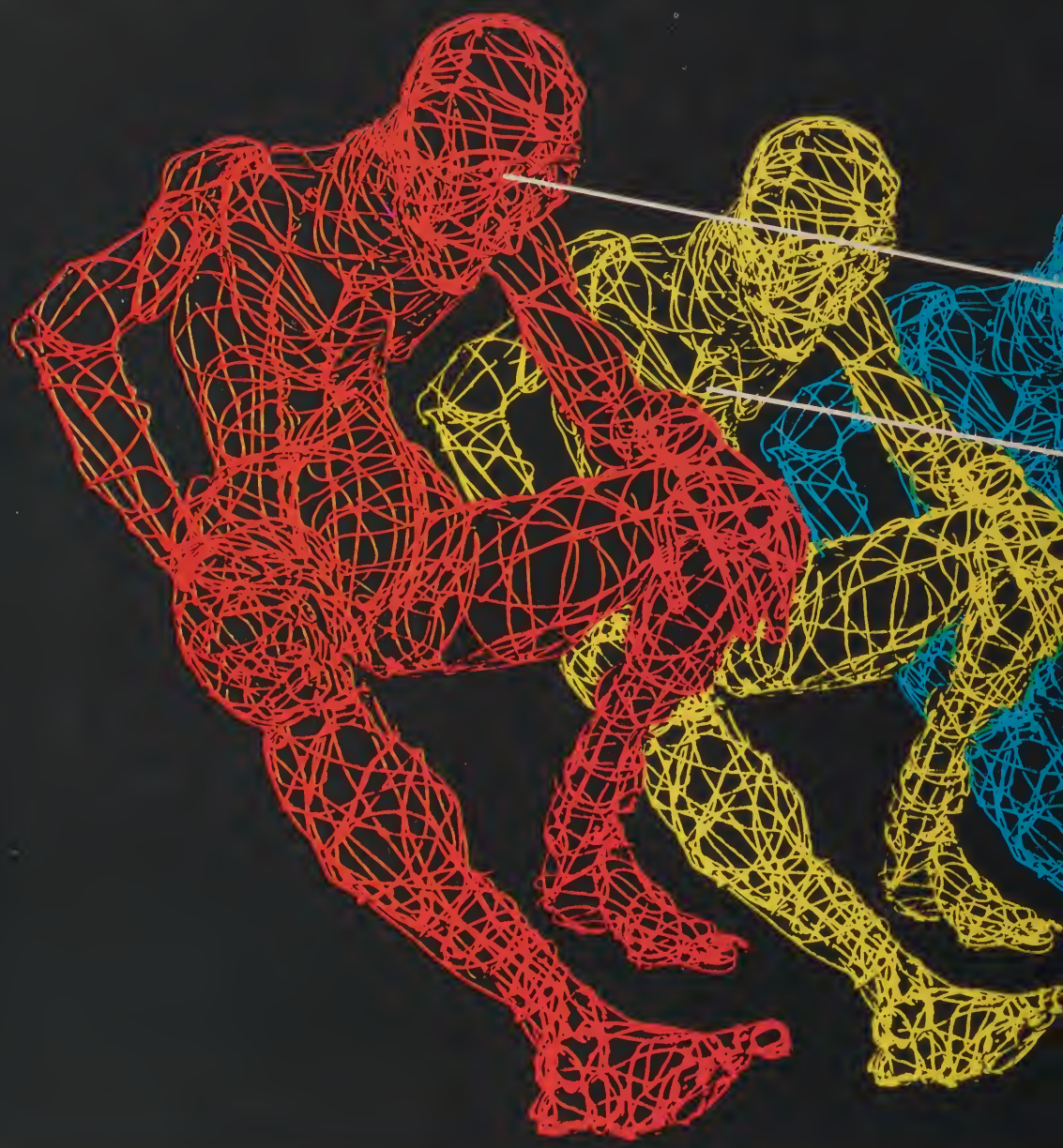
In men: When trichomonads are demonstrated, one 250-mg. oral tablet twice daily for ten days in conjunction with treatment of his female partner.

Dosage Forms: Oral tablets—250 mg.
Vaginal inserts—500 mg.

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Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150 mg.
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Iron, Elemental (as Ferrous Fumarate)	110 mg.
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Folic Acid	1 mg.

Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropr investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adeq vitamin B_{12} therapy may result in hematologic remission but e rological progression. Adequate doses of vitamin B_{12} (parenter or oral with potent intrinsic factor as in Trinsicon® [hemin concentrate with intrinsic factor, Lilly]) usually prevent, ha improve the neurological changes.

As with all preparations containing intrinsic factor, resistn may develop in some cases of pernicious anemia to the poten tion of absorption of physiological doses of vitamin B_{12}. If resi ance occurs, parenteral therapy, or oral therapy with so-ca massive doses of vitamin B_{12}, may be necessary. No single re men fits all cases, and the status of the patient observed follow-up is the final criterion for adequacy of therapy. Peo



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clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

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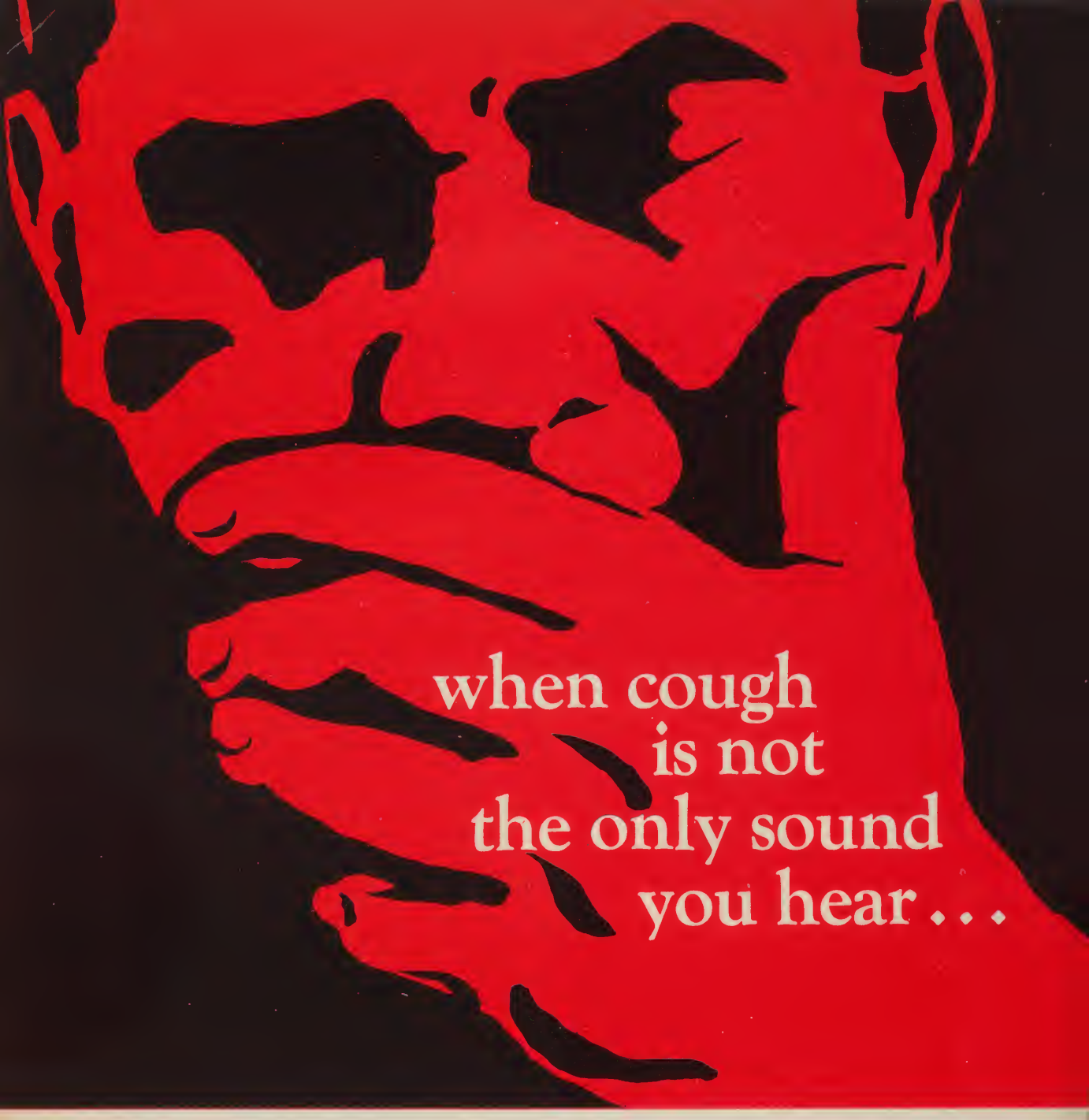
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The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

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'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

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STATE OF MARYLAND DEPARTMENT OF HEALTH

William J. Peeples, MD, MPH, Commissioner

HIGHLIGHTS

Laboratory Reporting Required by Law

The 1968 General Assembly enacted legislation requiring the directors of all clinical laboratories to report to the State Health Department all positive findings in examinations for tuberculosis, syphilis and gonorrhea. The report includes the name and address of the laboratory, patient identification, the name and address of the physician submitting the specimen and the type and result of the examination made. This report of a positive result does not constitute a final diagnosis of syphilis or gonorrhea. It is, however, the first step to the diagnosis of these diseases.

All such laboratory reports are strictly confidential and are not open to public inspection. Upon receipt of such notification the Health Department will contact the physician who submitted the specimen in order to determine the final clinical diagnosis. Under no circumstances will the Department make direct contact with the patient except by request or with the consent of the attending physician.

This law went into effect July 1, 1968. Inquiries regarding its operation should be addressed to the Division of Communicable Diseases, Maryland State Department of Health, 301 W. Preston Street, Baltimore 21201.

Drug Disintegration Test

Many tablet samples, although complying with official standards for potency and constitution, vary greatly in density, thus raising the question of disintegration time, an important factor in therapeutic efficacy. For this reason a Vanderkamp Tablet Disintegration Tester was recently acquired by the Drug Laboratory of the Environmental Chemistry Division.

This electrically controlled apparatus consists of a basket rack assembly, a suitable vessel for immersion fluid, a thermostatic arrangement for heating the fluid between 35° and 39° C, and a device for raising and lowering the basket in the immersion fluid at a constant frequency of 28 to 32 cycles per minute.

A recent complaint was that a type of sublingual nitroglycerine tablet required eight minutes to disintegrate. Analysis of a sample revealed disintegration in three minutes, which is in excess of the two-minute specification by the United States Pharmacopoiea. In the future, all tablets submitted for examination will be tested for disintegration time.

New Chief for Crippled Children's Services

Mary Alice Vann Fox, MD, has been appointed Chief, Division of Crippled Children's Services.

Dr. Fox has been serving as part-time pediatrician with the Comprehensive Health Care Program at Children's Hospital, D.C., and as a pediatric consultant in private practice. Formerly, she was in private practice in Bethesda, Md., where she also served as school medical adviser, clinician, acting chief of Division of Maternal and Child Health, and pediatric consultant for the Montgomery County Health Department.

Dr. Fox received her AB degree in biology from Women's College, University of North Carolina and her MD degree from the University of Pennsylvania School of Medicine. She is certified by the American Board of Pediatrics, and is a fellow of the American Academy of Pediatrics.

Quality Control Seminar for Maryland Laboratories

Federal-State-Community collaboration was exemplified at the recent two-day seminar on "Quality Control in Clinical Chemistry" conducted by the Department's Bureau of Laboratories. Principal faculty member was Joseph E. Boutwell, PhD, MD, Deputy Chief, Medical Laboratory Section, National Communicable Disease Center, Atlanta. Assisting him were Bureau staff and invited consultants from the Washington Hospital Center, the NIH Clinical Center, the Georgetown Medical School Department of Biochemistry, and pathologists from Mercy Hospital and a group laboratory in Baltimore. A total of 81 pathologists, technologists and laboratory scientists, including visitors from Ohio, the District of Columbia and Virginia, were instructed in methods for maintaining precision, accuracy, reproducibility and reliability in clinical chemistry analyses.

Federal Research Grant Awarded

The U.S. Department of Health, Education, and Welfare has approved a three-year grant to study methods and arrangements for full or maximum transfer of credits from the junior college curricula to the baccalaureate curricula in the respective professions of Occupational Therapy and Physical Therapy for those who wish to move from technical preparation and levels to professional functions.

Research phases will commence as soon as the grant is approved for acceptance by the Department of Public Works. Demonstration phases for occupational therapy are scheduled for September, 1968, and anticipated for physical therapy in September, 1969.

Communicable Disease Program Presented

Latest developments in the control of communicable diseases and immunization practices were recently reviewed by Health Department officials, meeting with preventive medicine officers and pediatricians from twelve military installations in Maryland. The full-day meeting, held at the State Office Building in Baltimore, was planned to acquaint the military base physicians with the facilities provided by the State and local health departments for communicable disease control

The program covered the subjects of venereal disease, tuberculosis, hospital infections, laboratory facilities, rabies and animal control, and the Department's current and planned Immunization Program and Birth Certificate Follow-up Activity.

Rocky Mountain Spotted Fever Diagnosis

During the summer months when ticks are most prevalent, cases of Rocky Mountain spotted fever will be reported to the Maryland State Department of Health. Treatment should be administered on the basis of clinical diagnosis, which is sometimes difficult. Laboratory confirmation is possible with the Complement Fixation test for antibody titer on two clotted blood specimens, acute and convalescent, drawn at an interval of at least 14 days. These may be submitted to the Bureau of Laboratories, Maryland State Department of Health, 16 E. 23rd Street, Baltimore 21218. The more reliable Complement Fixation has largely replaced the Weil-Felix tests for proteus OX-19 and OX-2.

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LIBRARY SECTION

Paul F. Guerin, MD, Chairman
Library and History Committee

Elizabeth Sanford, Librarian

Past and Future Meetings

By this time, two national library association meetings of interest to medical libraries will be history and new developments occurring since the 1967 conventions will have been thoroughly discussed, or at least presented to some two thousand librarians. Both the Special Libraries Association and Medical Library Association include members from other countries on the North American continent, so a good cross section of libraries is always apparent at these meetings.

MLA is entirely concerned with problems and subjects pertinent to the medical library, whereas SLA has the Biological Sciences Division which encompasses more than the strictly medical, hospital, and history of medicine libraries. Still another group of interest to the medical librarian is the Association of Hospital and Institution Libraries, a Division of the American Library Association (AHIL).

In Baltimore there are two library groups meeting regularly which include medical librarians; Baltimore Chapter, Special Libraries Association and the Baltimore Hospital Librarians Association. The SLA chapter requires membership in the national association, but the BHLA is open to any hospital or medical librarians without specific professional requirements.

* * *

Fifth Symposium on *Machine Methods in Libraries*

Will be presented by Washington University School of Medicine, St. Louis, Missouri, *if* enough people are interested. Actual machine methods in use at outstanding medical schools, the UN, and medical centers will be discussed. A 3-day meeting, November 1968, registration $35.00

Contact: Dr. Estelle Brodman, Librarian
School of Medicine Library, Washington University,
St. Louis, Missouri 63110

Third International Congress on Medical Librarianship

This important conference will be held in Amsterdam, May 5-9, 1969 with the Netherlands Library Association, Excerpta Medica, and the Ministry of Education of the Royal Netherlands Government jointly sponsoring it.

Theme: "World Progress in Medical Librarianship."

Watch your MLA News and Bulletin for details.

Delaware—D.C.—Maryland Hospital Association Hospital Librarians' Luncheon

The first librarians' program for this group will be presented at a luncheon meeting on December 3, 1968, with the Baltimore Hospital Librarians Association responsible for the program.

* * *

MEDICAL LIBRARY PUBLICATIONS

A most welcome addition to professional library literature is the new edition of the bibliography which was formerly a part of the 1956 edition of the Handbook of Medical Library Practice. Since bibliographies rapidly become out-of-date it was decided to publish the bibliog-

raphy separately under the title *Medical Reference Works, 1679-1966,* edited by John B. Blake and Charles Roos, 1967. Annotated by over 50 specialties, with 2700 entries.

Available from: Medical Library Association
919 North Avenue
Chicago, Illinois 60611
Send check with order—$10.00

Visit the Library Collection at Ocean City meeting

New Accessions: BOOKS (Arranged by author and title)

R 15
A5
1965
American Medical Association. Division of Socio-Economic Activities.
Nationwide survey of county medical society activities, 1965. Chicago, American Medical Association, 1967.

Ref.
RA
421
A5
American Public Health Association.
Membership directory. 1967. New York, N.Y. American Public Health Association.

RA
1270
.P4A5
1967
American Public Health Association. Subcommittee on Pesticides. Safe use of pesticides; a manual for public health personnel. New York, N.Y., American Public Health Association, 1967.

Ref.
R
712
A1A7
Association of American Medical Colleges.
Directory. 1968. Chicago, Association of American Medical Colleges.

RB
155
B3
1967
Bartalos, Mihaly:
Medical cytogenics. Baltimore, Williams & Wilkins Co., 1967.

RG 101
B7
1967
Brewer, John Isaac:
Textbook of gynecology. 4th edition. Baltimore, Williams & Wilkins, 1967.

RD 575
C6
1966
Conference on the Kidney, 16th annual.
Homotransplantation, kidney and other tissues, edited by Jack Metcoff. New York, National Kidney Foundation, 1966.

RM 101
C8
1967
Cuba. Ministerio de Salud Publica. Comisión del Formulario Nacional.
Preparaciones oficinales y extemporáneas. Havana, Cuba. Ministerio de Salud Publica, 1967.

RC 48
F4
1967
Feinstein, Alvan R:
Clinical judgment. Baltimore, Williams & Wilkins, 1967.

RC
126
.F4
1967
Felsenfeld, Oscar:
The cholera problem. St. Louis, W. H. Green, 1967.

R 507
.P3 H3
1967
Hamby, Wallace Bernard:
Ambroise Paré, surgeon of the Renaissance, St. Louis, W. H. Green, 1967.

Ref.
RA
963
H6
1968
Hospital Council of Maryland, Inc.
Planning. Services and facilities in Maryland hospitals. Baltimore, Hospital Council of Maryland, Inc. 1968.

RA 972
I5
1966
Illinois. Dept. of Public Health.
Housing selected gynecological patients in obstetrical units. Springfield, Ill. Illinois Department of Public Health, 1966.

R 145
K7
1962
Krantz, John Christian:
A portrait of medical history and current medical problems. Baltimore, printed for the author by the John D. Lucas Printing Co., 1962.

RE 46
M3
1967
Martin-Doyle, John Lionel Cyril:
A synopsis of ophthalmology; with a foreword by H. B. Stallard. 3d. edition. Bristol, J. Wright, 1967.

Ref.
RA 412.6
M3
1960
Maryland Medical Service, Inc.
Steel program effective Jan. 1, 1960; schedule of fees and information for physicians. Baltimore, Maryland Medical Service, Inc. 1960.

R 15.A5
M4
1968
Medical Association of the State of Alabama. Special session Jan. 4, 1968, Montgomery, Alabama.
Handbook for counsellors and delegates. Montgomery, Medical Association of the State of Alabama, 1968.

RC 186
.T85P6
1967
Pollitzer, Robert:
History and incidence of tularemia in the Soviet Union, a review. Bronx, New York, Institute of Contemporary Russian Studies, Fordham University, 1967.

Ref.
PE 1628
R3
1967
The Random House dictionary of the English language.
Jess Stein, editor in chief. Laurence Urdang, managing editor. New York, Random House, 1967.

R 141
R4
n.d.
Regimen Sanitatis Salerni:
The school of Salernum, the English version by Sir John Harington. Salerno, Ente Provinciale per il Tarismo, n.d.

RG 107
S7
1967
Steptoe, Patrick Christopher:
Laparascopy in gynaecology; with a foreword by W. I. C. Morris. Dr. H. Frangenheim contributes a section on sterility. Edinburgh, London, E.&S. Livingstone, 1967.

RC
267
U5
1967

Ullman, S. B.:
New vistas of chemotherapy of cancer. Toronto, privately printed, 1967.

Ref.
HA
37
U6

U.S. Bureau of the Budget. Office of Statistical Standards.
Federal statistical directory. 21st edition. January 16, 1967. Washington, D.C. 1967.

Ref.
R 100
U65

U.S. National Institutes of Health.
Scientific directory and annual bibliography. 1968. Washington, U.S. Government Printing Office. 1968.

R 729.5
.G6 U6
1967

U.S. Public Health Service. Division of Medical Care Administration.
Promoting the group practice of medicine; report of the National Conference on Group Practice, October 19-21, 1967, held at the Center for Continuing Education, University of Chicago. Washington. U.S. Dept. of Health, Education, & Welfare. 1967.

RC 313
U6
1966

U.S. Public Health Service. National Communicable Disease Center.
Reported tuberculosis data, 1966. Washington, USGPO 1968.

Ref.
RA 445
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1967-

U.S. Public Health Service. National Institutes of Health. Division of Regional Health Programs.
News, information, data, May 1967. Bethesda, Md., U.S. Dept. of Health, Education, and Welfare, 1967-

Ref.
RA 1051
W3
1966

Wasmuth, Carl Erwin:
Law for the physician. Philadelphia, Lea & Febiger, 1966.

RC 857
W4
1966

White, Thomas Taylor:
Pancreatitis. London, Edward Arnold. 1966.

AY
67.N5 W7
1968

The World Almanac and Book of Facts. 1968.
New York, The New York World-Telegram. 1968.

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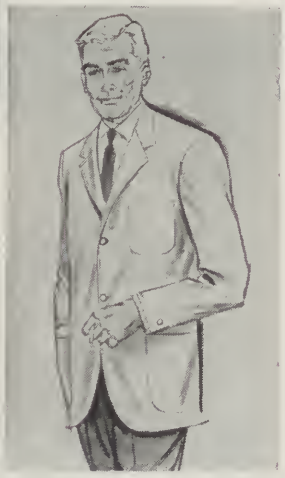


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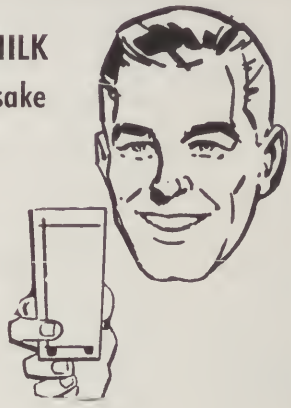
Physicians Favor Lifting of Ban on LSD

Although the Federal Government now bans the manufacture, distribution, sale and use of LSD, four out of five physicians are opposed to this ban.

According to the results of the monthly national physician opinion poll (Playback), conducted late in March by Marion Laboratories, Inc., the overwhelming majority of physicians, 66%, believe that the ban should be lifted to allow LSD to be used for "limited" research.

An additional 14% of physicians questioned believe that LSD should be made generally available for clinical research.

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Why the Physician Should Write . . .

And to Whom

Physicians certainly do write. In his lifetime, the physician has three distinct audiences. He must write to only one small portion . . . he may choose to write to the others.

JOHN GORRELL, MD
Riverside, California

1. Himself: The physician is required to write if he is to practice medicine. This writing includes hospital and office records and reports. However, doctors may write for rewarding and personal reasons, such as for self-discipline, as a hobby, for income and prestige, or even as an escape.
2. Medicine: The physician may write for medicine, but he should be strongly discouraged unless he really has something worth contributing. He should be punished if he writes or delivers papers which add nothing appreciable to the Niagara of medical literature.
3. Public: He is not required to write for the public. The public eagerly awaits the words of the physician if they are interesting and clear. Most physicians, as professional men and representing an honorable profession, should write for the public. Often their pens will be more effective here in protecting medicine than in adding to its scientific literature.

The surgeon may spend more time with pen in hand than with a scalpel. Whereas medical education is strong in the teaching of science, it can be equally feeble in teaching communications. The physician may be more skilled in the use of drugs than in the use of words. His ability to diagnose the patient's illness is often greater than his ability to express himself to his patient.

Physicians, then, feel that writing is especially difficult for them. Surprisingly, these exact words come from lawyers, clergymen, politicians, and even from some professional writers! If you doubt this, remember that ancient immutable law which says "The easier it is to read, the harder it was to write." This parallels evaluation of the physician where "the slicker" the surgery, the greater the surgeon's skill . . . the "sharper" the diagnosis, the greater the ability of the internist.

Every time the physician sees a patient, he should automatically reach for his pen. First he records the history and the results of the physical examination. Then there are orders, prescriptions, follow-up notes, insurance forms, summaries, letters and referrals. Finally there are notes so that the patient or the insurance company can be billed.

Some physicians do not write thoughtfully or carefully. Such a man may find himself without a hospital, or even a medical license. He may not only be deprived of a means of earning a living, but he can find himself swallowed up by lawsuits. This unfortunate person begrudgingly writes to exist. He takes even simple writing as an imposition, if not a persecution.

Conversely, many physicians know that, with the right attitude, writing need not be a chore or punishment. It can be a challenge and an opportunity. It may be a liability for some of his unfortunate colleagues, but for him it is neatly converted to an asset.

Reprinted from *The New Physician*, August, 1967.

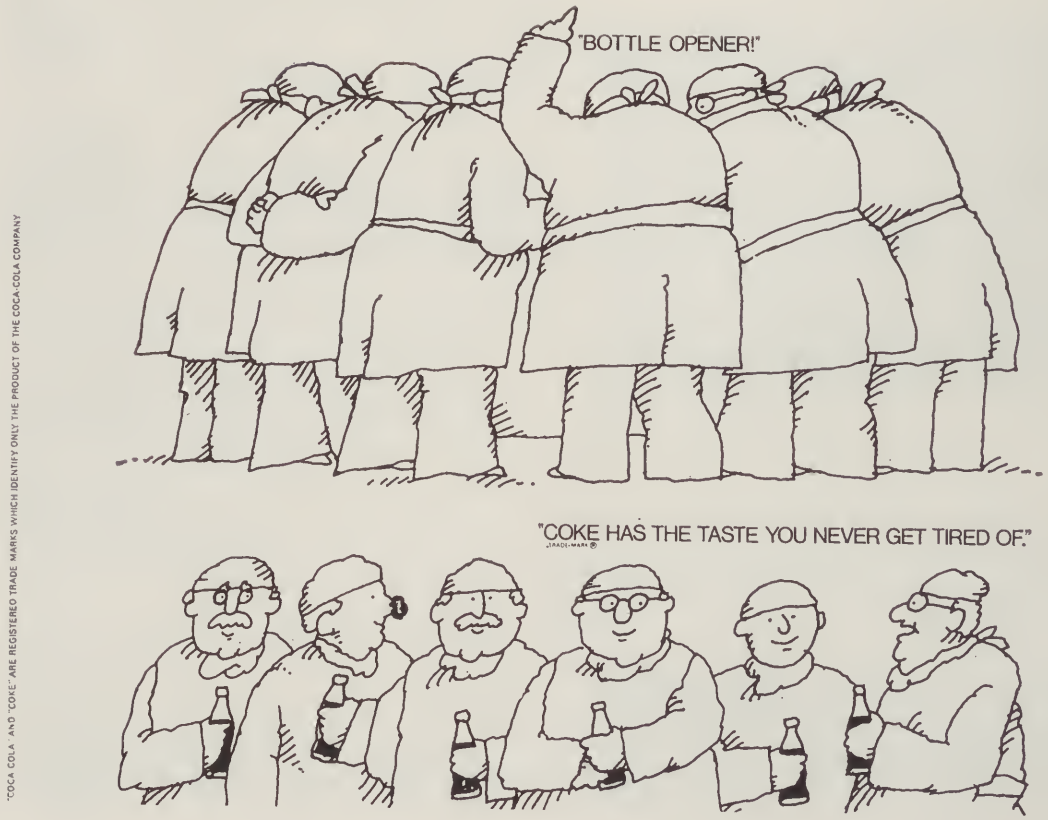
Writing is much like painting a house. You must build the house before you can paint it. This mental house is not of bricks and timber built on land, but consists of wisdom and skill built on knowledge. Collectively, your intellectual house is known as thinking and your painting is known as writing. The problems of writing are actually the problems of thinking. And what professional group should be better trained and practiced in thinking and writing than that of a physician? For a thousand years, medicine has developed the proven methods of fact-gathering and fact-weighing. Each physician accumulates great experience in gathering and using information. Only in this way can the best diagnosis and treatment be possible.

The periodic review, the "auditing" of medical practice, is based on the presumption that everything and anything of importance done for the patient, or to him, is a matter of written record. This is especially true in the hospital. Everyone writes . . . nurses, administrators, accountants, pharmacists, and physicians. Probably at no other time in his life is there so much and such precise information recorded about a person as when he is a hospital patient. His hourly care, reactions, and treatment are permanently recorded. And to only a somewhat lesser degree should his records be kept in his doctor's office.

Far beyond the legal and medical reasons for writing for himself, there are other benefits. The physician who learns to express himself finds a new and wonderful satisfaction. He may write little things like letters to the editor or big ones like a newspaper health column (an article for a medical journal), or even a book!

Writing can be a wonderful hobby. However, one does not start off with great skill. As Osler often said, "The doctor must be satisfied if his writings of the first ten years are acceptable only to the wastebasket."

These are the training years. The physician learns the frightening task of facing a sheet of blank paper, knowing that squirming in his chair or chewing his pencil will not put a single thought on that sheet. Yet, when the writing task is completed, he will discover that he is a better physician, that he thinks more clearly, and that he does his medicine "right" the first time, because he has had to think it through before he could write it.



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When the brainchild of his mind has been delivered by the forceps of his pen, there is no greater sense of satisfaction, no finer glow of inner warmth.

The physician, who writes a successful paper, or more especially a book, earns the awed respect of patient and colleague. To have "been published" means that even his enemies will doff their hats. Almost everyone knows something of the tenacity, strength, and courage required to "be published." Society has a special type of pedestal reserved only for the man who writes successfully. It is pure alabaster if he is a physician and successfully writes in a non-medical field!

The physician may write to be published and thus benefit by the usual glories and prestige. Many a physician has written as a hobby, often under a pen name. Writing can be a thrilling hobby, whether it be A. Conan Doyle with Sherlock Holmes or Frank Slaughter and his novels. It can be a means of escape from daily pressures.

This hobby does not require a golf course, a boat, or hunting equipment, or even a mystery book. The physician can escape at the turn of a thought and the closing of an eye. He can think, plan, plot, and wrestle with his ideas at any time and any place, for minutes or even seconds. This can fit into any of the time chinks of the day. When mind and body are fatigued, the subconscious mind carries on a fantastic work for him.

Thus, early in life, the physician writes for himself . . . this is his "first" audience. He does part of his writing because he is required to do it if he is to practice medicine.

However, when writing for himself, there are desirable personal rewards. He improves himself, not only as a physician, but as a man. Thus, he becomes more precise in everything he does because he thinks more clearly, more easily.

He has probably heard those in the exact sciences say, "If you cannot express it in figures, you don't know what you are talking about . . . and neither does anyone else." Medicine is not an exact science so the doctor may modify this rule to read . . . "If you cannot express yourself in words, it is doubtful you really know much about your subject . . . or perhaps that you have not even thought it through."

Writing is part of the medical education and medical practice of the physician. It is best if he learns to do it easily, skillfully, and even with pleasure. But write he must.

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Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
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WOMAN'S AUXILIARY TO THE MONTGOMERY COUNTY MEDICAL SOCIETY

The 20th anniversary of the Woman's Auxiliary to the Montgomery County Medical Society was celebrated at a birthday party held at the Manor Country Club on May 21st.

To commemorate the event, each past president summarized the history of the organization during the time she was in office.

When the Auxiliary was started it consisted of a handful of doctors' wives who met in each other's homes. Twenty years later the group had grown to a membership of 200.

From the very beginning the members have endeavored to extend the aims of the medical profession. Among those who have benefitted from the tireless efforts of the members are nursing students who have received full or partial scholarships to Sinai Hospital in Baltimore, the University of Maryland, Washington Sanitarium and Montgomery Junior College.

Each year the Auxiliary has supported the American Medical Association's Education and Research Foundation Program and has donated to the Mental Health Program at Springfield Hospital in Baltimore. This year, the handicapped people of Montgomery County benefitted through assistance given to the Montgomery Workshop in Silver Spring.

During the celebration the officers for 1968-69 were installed by Mrs. William Stone, immediate past president of the Auxiliary to the Medical and Chirurgical Faculty of Maryland. Mrs. Gordon Smith was installed as president; vice president is Mrs. Hewitt Varney; Mrs. Francis Mayle is the president elect; and Mrs. Cyril Hardy is the new secretary; treasurer is Mrs. Richard Lukes; corresponding secretary is Mrs. George Schonholtz.

Mrs. John Umhau, Jr. is the out-going president of the organization.



Mrs. John Ball (left), first vice president of the Auxiliary, cuts the birthday cake to celebrate the organization's 20th anniversary, while Mrs. William Stone (center), immediate past president of the Woman's Auxiliary to the Medical and Chirurgical Faculty of Maryland, looks on with Mrs. John Umhau, Jr., 20th president of the Montgomery County Auxiliary.

Information for Authors

MANUSCRIPTS: Manuscripts will be accepted for consideration for publication with the understanding that they are original, have never before been published, and are contributed solely to the Maryland State Medical Journal.

All manuscripts are acknowledged upon receipt and are followed up by notification of either acceptance or rejection. Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the Journal and are not returned. The Journal is not responsible for loss of manuscripts through circumstances that are beyond its control.

Manuscripts should be addressed to: Editor, Maryland State Medical Journal, 1211 Cathedral St., Baltimore, Md. 21201.

SPECIFICATIONS: Manuscripts must be original typed copy, doublespaced throughout (Including text, case reports, legends, tables and references) with margins of at least 1½ inches. Pages should be numbered consecutively.

The manuscript should include the title (brief and concise), the full name of the author (or authors) with degrees, academic and professional titles, affiliations, and any institutional or other credits. Please include a complete address where the author may receive proofs of his article for his approval and corrections.

All manuscripts should be accompanied by a carbon or xerox copy and the author should retain another copy for his records.

TABLES: Each table should be typed on a separate sheet of paper, be numbered, have a brief descriptive title, and its position in the text should be indicated.

Be sure that statistics are consistent in both tables and text.

REFERENCES: References should be limited to those citations noted in the text, and kept to a minimum of 18. (A complete review of the literature is rarely desirable.) The references must be typed, doublespaced, and are to be numbered consecutively as they appear in the text, with their positions in the text indicated. An alphabetized bibliography is used only when the listing is of books suggested for supplementary reading.

All references must be checked for absolute accuracy. Each journal reference must include author(s) and initials, complete title of article, name of publication, volume, first page of article, and date. Complete dates (month, day, and year) are to be included with all references that have appeared within the last three years. Include with book references name of author(s) and/or editor(s) with initials, title of book, edition, location, publisher, year, volume (if given), and page. If reference is to a chapter within a book, include the author of the chapter, (if different from author of the book), and the title of the chapter, if any.

ILLUSTRATIONS: Authors are urged to use the services of professional illustrators and photographers when possible. Drawings and charts should always be done in black ink on white paper. Clear, glossy photographs, black on white, should be submitted and such illustrations numbered consecutively and their positions indicated in the text.

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Legends for illustrations should be typewritten on a separate page with numbers corresponding to those on the photographs and drawings.

Recognizable photographs of patients are to be masked and should carry with them written permission for publication.

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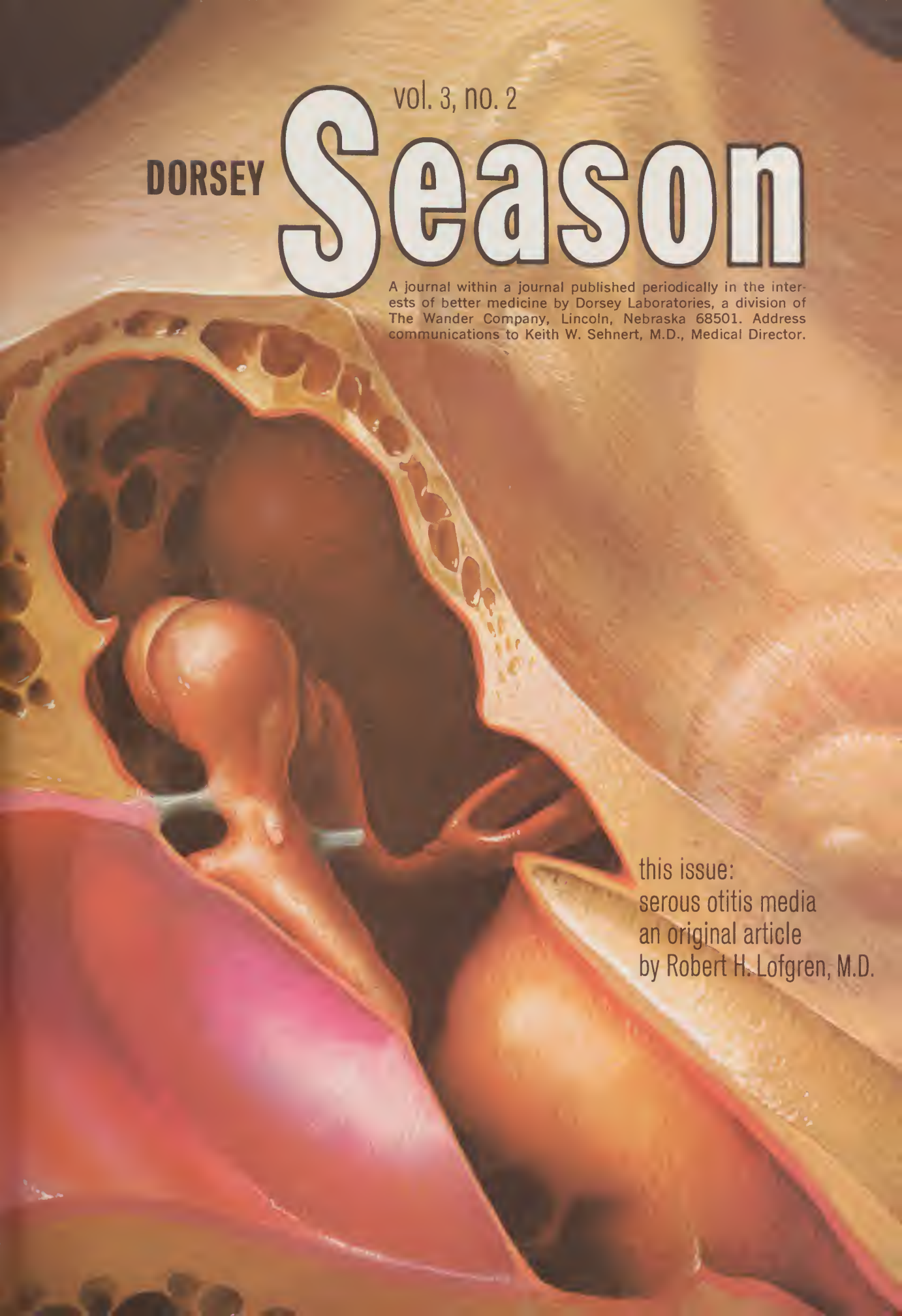
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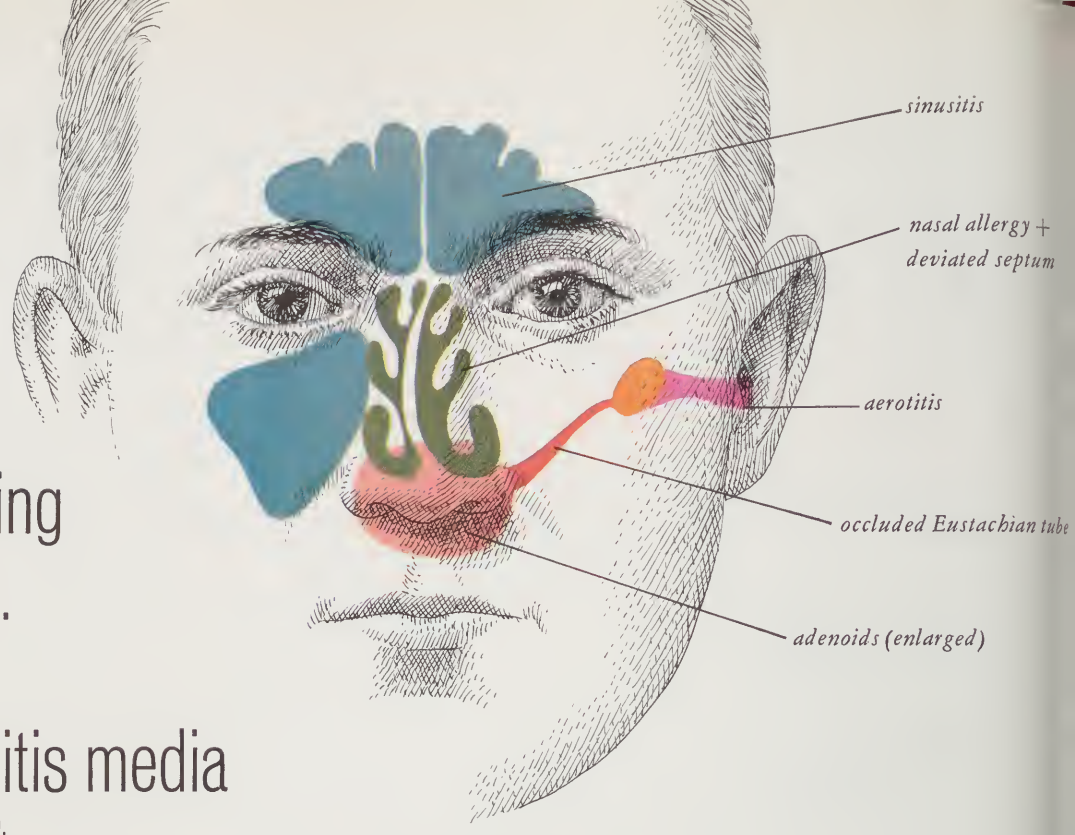
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this issue:
serous otitis media
an original article
by Robert H. Lofgren, M.D.



the complaining earache... key to serous otitis media

Robert H. Lofgren, M.D.
Associate Surgeon, Massachusetts Eye and Ear Infirmary, Boston, Massachusetts

Serous otitis media is probably the most common ear problem in children, especially in the wintertime. Diagnosis is usually easy in adults, but may be quite difficult in children, especially the very young child where one has to depend almost entirely on the physical findings.

The symptoms of serous otitis are a fullness in the ear, a mild hearing loss and mild earache. The earache can best be described as a "complaining earache" instead of a "screaming earache" as found in purulent otitis media. A young child may be irritable and pull at the ear. In milder cases, and as the ear recovers, gurgling and popping noises can be heard in the ear.

On examination one may see a yellow tympanic membrane and if a fluid level is present the diagnosis becomes easy. However, the eardrum may be dull gray, or slightly pink, or even perfectly normal. Pneumomassage using a Siegle otoscope or a closed-head electric otoscope must be done on both ears, otherwise the diagnosis will be frequently missed. Attempted movement of the drum with the pneumatic otoscope produces either a sluggish motion of the drum or no motion at all instead of the easily movable normal drum. The Rinne test is negative and there is a 15-20 decibel conductive hearing loss. The bone conduction may be better than normal and an air-bone gap may exist even with the air conduction within normal limits. Occasionally one finds a false nerve deafness on the audiogram when thick glue-like fluid causes immobility of both the oval and round window. Both conditions return to normal when the fluid is removed, but they make the interpretation of screening audiograms very difficult.

There is no single cause for serous otitis. One factor always present is blockage of the eustachian tube, but this alone is not enough to produce fluid. There must also be an inflammatory reaction. Blockage of the eustachian tube may be caused by many conditions. In children the most common cause is enlarged adenoids. In the summer the next most common cause is allergy. Upper respiratory infections or influenza are common causes in the winter. Nasal allergy, acute and chronic sinusitis, nasal septal deformity and cleft palate can all cause eustachian tube obstruction. Some children may have a congenitally small eustachian tube, but fortunately they usually "grow out of the problem."

The first sign of a nasopharyngeal tumor is often a serous otitis. One must always rule this out in any adult who later in life develops repeated or persisting serous otitis. Causes sometimes overlooked are nasogastric tubes after surgery, simple obesity and cardiorenal disease, which may produce congestion in the mucosal lining of the eustachian tube. In recent years we have been seeing a new cause—acute otitis media, where the patient is adequately treated with antibiotics but where drainage has not been

established either through the eardrum or down the eustachian tube. A sterile exudate is left in the middle ear.

The inflammatory response may be caused by a marked negative pressure as in air otitis from flying, or it may be from a mild bacterial or viral infection in the middle ear. Serous fluid is a good culture medium and will frequently go on to purulent otitis media, especially if the original blockage was caused by an infectious process such as acute rhinitis or adenoiditis. When the infection heals there may be scarring in the middle ear mucosa. Mucous glands develop in this tissue and pour out a thick mucoid material. This ear usually looks normal until a pneumatic otoscope is used. The objectives in treating serous otitis are to remove the obstructing agent and to provide drainage from the middle ear. Often this can be accomplished by decongestants and nose drops. If large obstructing adenoids are present they should be removed. Sinusitis should be treated with oral decongestants or nose drops, plus antibiotics where indicated. Nasopharyngeal tumors should be treated. Allergies should be treated with antihistamines and, where indicated, by desensitization.

If the fluid does not clear with medical treatment within a week or two, a myringotomy should be done. If there is a question of active infection or if the fluid looks purulent, as is seen at the conclusion of acute otitis, cultures are taken. On adults this can be done in the office without anesthesia. It is no more painful than an intravenous needle for a blood test. A good safe topical anesthetic has a tremendous psychological value to the patient. Children under the age of 1 require no anesthesia. Between the ages of 1 and 3 anesthesia is not absolutely essential although a general anesthetic may be used to avoid the child's possible mistrust at follow-up examinations. I usually do the myringotomy at the same time as the adenoidectomy if the adenoids are enlarged. Once drainage has been established with decongestants or by myringotomy, positive pressure inflation of the middle ear is invaluable in forcing out the serous fluid and keeping it from reforming. The patient can do this himself by performing the Valsalva maneuver. This should be done several times a day, by taking a deep breath, holding the nose and blowing hard against the closed lips for a second or two.

In resistant cases where the fluid reforms as soon as the myringotomy heals, small polyethylene tubes are inserted through the myringotomy site. Insertion of the tubes, even in adults, usually requires an anesthetic. Good anesthesia can be obtained by infiltrating the canal wall with a local anesthetic, using a #27 needle. Once inserted the patient has no sensation of the tubes' presence. Be careful to caution the patient or parents not to allow any water to get into the ear canal while a myringotomy is open or a tube is in place. Water can be kept out by a pledget of lamb's wool in the ear canal or a cotton pledget thickly coated on the outside with petroleum jelly. I check these patients a week after a myringotomy to be sure it is healed and at two month intervals until the tubes have fallen out, usually within three to six months after insertion.

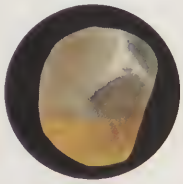
The mucoid type of fluid is so thick and tenacious that it is appropriately called a glue ear. It is aspirated only with difficulty through the eardrum, and occasionally must be removed through a tympanotomy. This thick, glue-like fluid is prone to recur, as the myringotomy usually heals long before the mucous membrane has returned to normal. Repeated myringotomies, as many as ten or twenty, were formerly required for this condition. Now polyethylene tubes are inserted initially when this thick, glue-like material is found. At times a subacute mastoiditis may accompany the serous otitis, which will necessitate a simple mastoidectomy before the condition can be eradicated. Usually the thin serous fluid readily responds to decongestants or to a myringotomy and removal of the eustachian tube obstruction. Occasionally, however, even serous fluid will repeatedly reform. For this, resection of the tympanic plexus of nerves which lies on the promontory of the middle ear has been carried out, as the tympanic branch of the glossopharyngeal nerve is the secretomotor nerve to the ear.

Failure to diagnose serous otitis is the most common cause of the recurrent, almost continuous otitis me-

Otoscopic Views



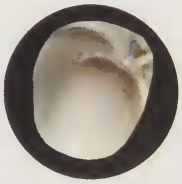
Normal



Acute Serous



Acute Purulent



Chronic Serous

dia seen in young children. In these cases a myringotomy will frequently provide a long-term cure without adenoidectomy or any other surgery. Failure to do this may allow the condition to go on to acute or subacute mastoiditis. Adhesive otitis media with scar tissue binding down the ossicles or tympanosclerosis may also result with permanent impairment of hearing. The prognosis for hearing with adhesive otitis or tympanosclerosis is usually poor. If the adhesions are removed, they reform, and the same is frequently true of tympanosclerosis even after a tympanoplasty. For many of these people a hearing aid is the only solution. The constant negative pressure in long standing serous otitis media may draw in either Schrapnell's membrane or the posterior superior portion of the eardrum forming a pocket to cause a chronic otitis media with cholesteatoma, which may not become apparent until twenty or thirty years later.

The non-medical complications of improper diagnosis or treatment may be even more serious. The irritable child, the frequent bouts of acute purulent otitis media with pain and fever, the expense of antibiotics and doctors, and the time lost from school or work affect the entire family.

In summary, serous otitis has many causes. There is a blocking of the eustachian tube and an inflammatory reaction in the middle ear mucosa, the latter usually caused by a mild infection. The treatment is to provide immediate drainage by decongestants and where necessary, by a myringotomy. The obstructing agent must be removed by surgery if it is adenoid or by oral decongestants, and antihistamines or nasal spray if it is an upper respiratory infection or allergy. Occasionally resistant cases require plastic tubes placed through the eardrum or other more radical surgery. Failure to treat properly leads to hearing loss which may be permanent, repeated acute otitis media or possibly even chronic otitis media with cholesteatoma.

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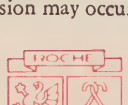
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AUGUST 1968

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ON THE COVER: The Cover sketch as well as the illustrations accompanying the articles from the Pediatrics Symposium were executed by **Aaron Sopher,** a well-known Baltimore artist. Mr. Sopher's simplicity of detail and underlying wit have made him a favorite with both beginning collectors and the more sophisticated art lovers of the world. The staff of the **Journal** is indebted to Mr. Sopher for his superb addition to this issue.

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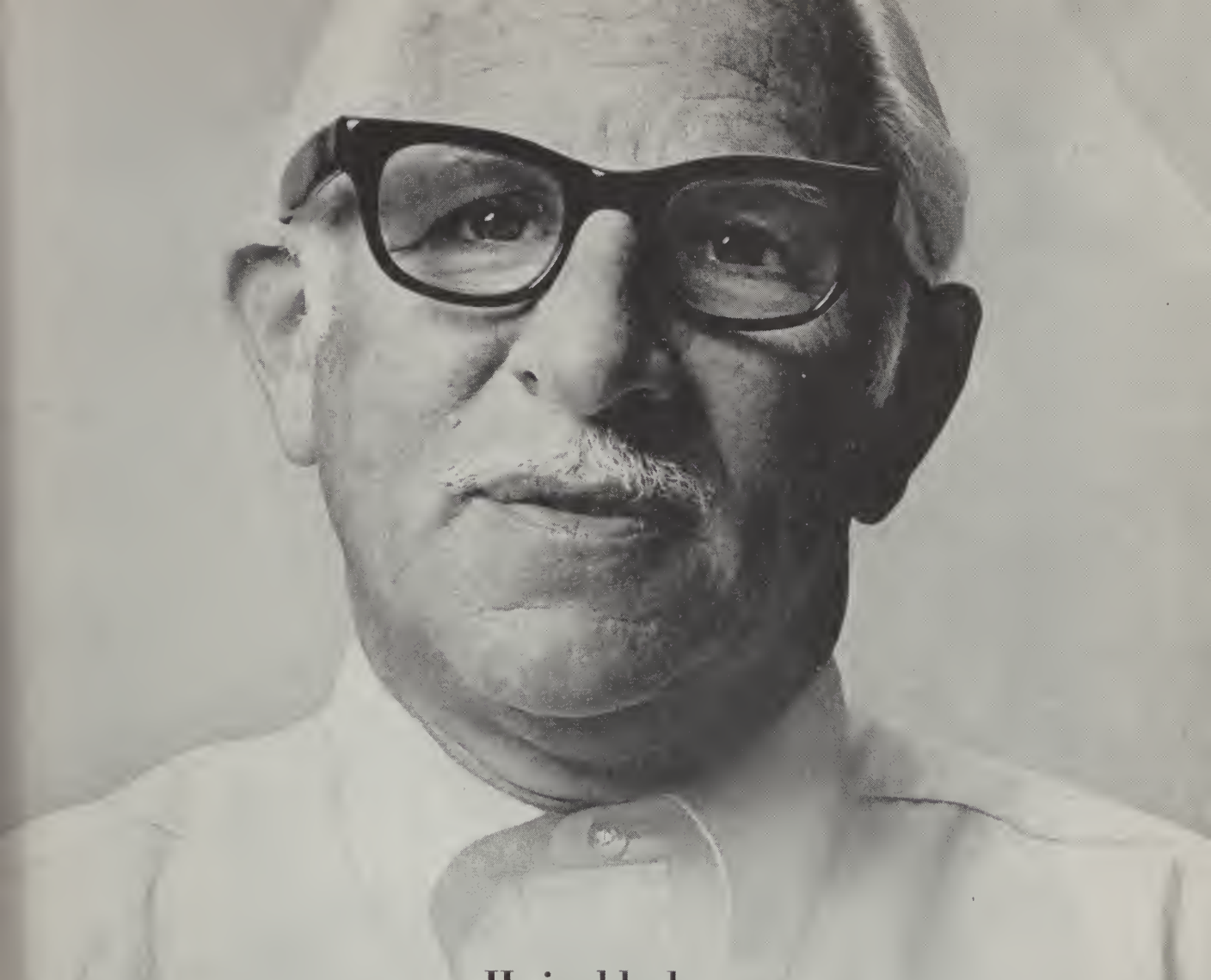
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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken.

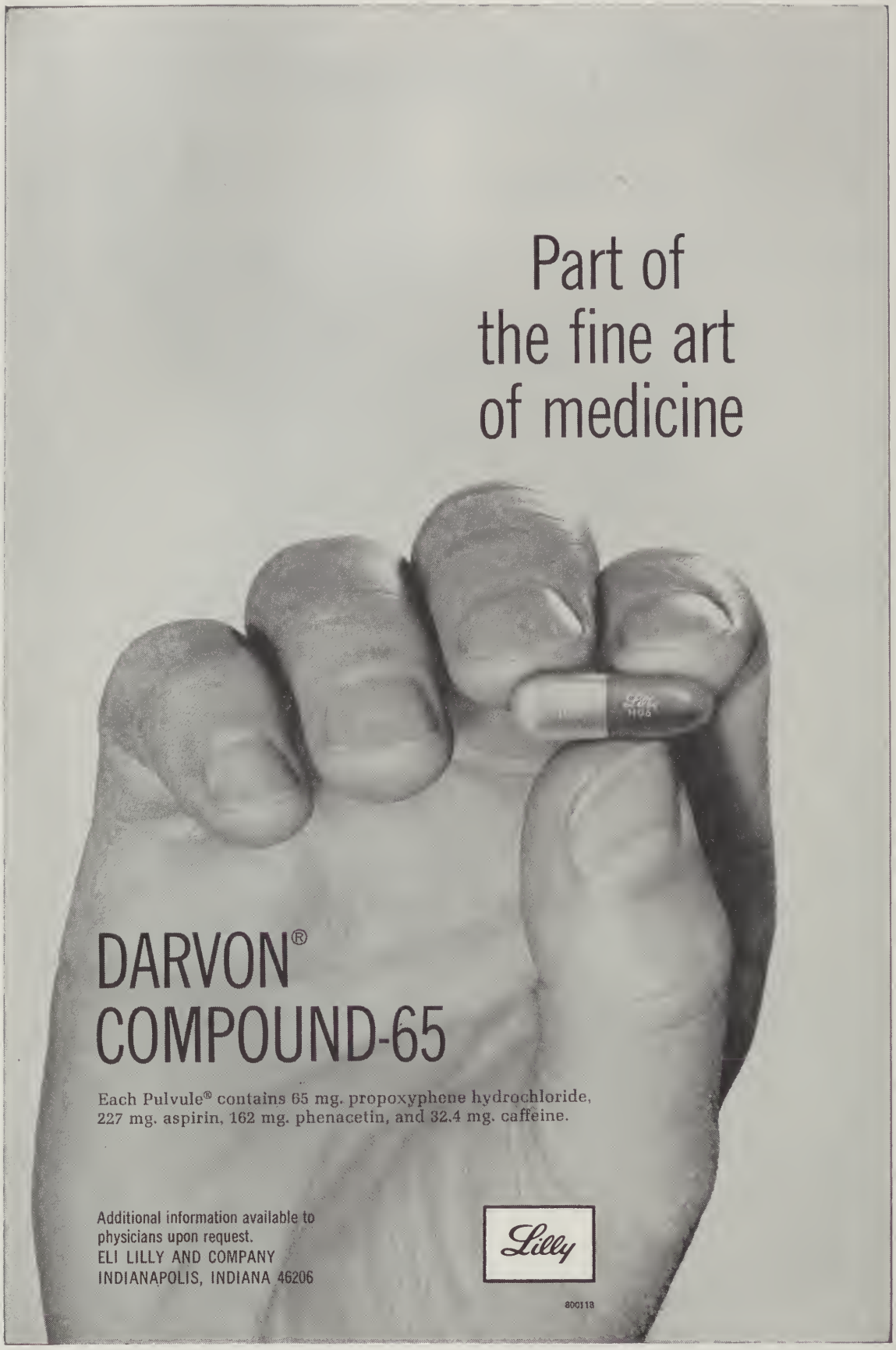
In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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AUGUST 22-24, 1968
UNIVERSITY OF WISCONSIN MEDICAL SCHOOL, DIVISION OF CLINICAL ONCOLOGY

Conference—Cancer Chemotherapy '68: Park Motor Inn, Madison, Wisconsin. Open to all United States physicians interested in cancer chemotherapy. Director: Fred J. Ansfield, MD. Contact: Fred J. Ansfeld, MD, University of Wisconsin Medical School, Division of Oncology, Madison, Wisconsin.

SEPTEMBER 7-11, 1968
THE JOHN A. HARTFORD FOUNDATION, INC./TRANSPLANTATION SOCIETY

Second International Congress—Review of progress in field of organ and tissue transplant with prominent specialists leading discussions on transplantation of organs, including kidney, heart, liver, lung and the body rejection of alien tissue: Imperial Ballroom of Americana Hotel, New York. Contact: Felix T. Rapaport, New York University Medical Center, 560 First Avenue, New York, N.Y.

SEPTEMBER 9-11, 1968
AMERICAN EEG SOCIETY

Continuation Course—Clinical Electroencephalography, basic review of applications of EEG to clinical medical practice: San Francisco, California. Contact: Donald W. Klass, MD, EEG Course Director, Mayo Clinic, Rochester, Minnesota 55901.

SEPTEMBER 17, 1968
HEART ASSOCIATION OF WESTERN MARYLAND

Meeting—Executive Board of Heart Association of Western Maryland: 6:30 P.M.

SEPTEMBER 18-20, 1968
AMERICAN CANCER SOCIETY/NATIONAL CANCER INSTITUTE

Conference—Sixth National Cancer Conference: Denver Hilton Hotel, Denver, Colorado. Open to all physicians and medical students. Contact: American Cancer Society, Maryland Division, Inc., 20 East Eager Street, Baltimore, Maryland 21202.

SEPTEMBER 19, 1968
HEART ASSOCIATION OF MARYLAND/MARYLAND HEART CHAPTERS

Meeting—Committee on Volunteer Activities: 1 P.M., Heart Offices. Contact: Heart Association of Maryland, 415 North Charles Street, Baltimore, Maryland 21201.

SEPTEMBER 19, 1968
HEART ASSOCIATION OF MARYLAND/MARYLAND HEART CHAPTERS

Meeting—Executive Committee: 4 P.M., Heart Offices. Contact: Heart Association of Maryland.

SEPTEMBER 20-27, 1968

NINTH INTERNATIONAL CONGRESS OF NEUROLOGY AND FOURTH INTERNATIONAL CONGRESS OF NEUROLOGICAL SURGERY

Scientific Meeting/World Congresses of Neurological Sciences—Epilepsy and Cerebral Vascular Disease: New York Hilton Hotel, New York,N.Y. Directors: Houston Merritt, MD, A. Earl Walker, MD. Contact: Office of the World Congresses of Neurological Sciences. 420 Lexington Avenue, Suite 417, New York, New York 10017.

SEPTEMBER 26, 1968

UNIVERSITY OF PENNSYLVANIA SCHOOL OF MEDICINE, GRADUATE DIVISION

Postgraduate Course—Medical Hypnosis: Institute of the Pennsylvania Hospital, 111 North 49th Street, Philadelphia, Pennsylvania 19139. Director: Sydney E. Pulver, MD. Open to physicians and dentists. Contact: Office of the Director, Division of Graduate Medicine, 237 Medical Laboratories, University of Pennsylvania, Philadelphia, Pennsylvania 19104.

SEPTEMBER 26-29, 1968

AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—The Metabolic Basis of Heart Disease: Wayne State University School of Medicine, Detroit, Mich. Co-Directors: Thomas A. Bruce, MD, FACP, Richard J. Bing, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

SEPTEMBER 26, 1968-DECEMBER 12, 1968

THE INSTITUTE OF THE PENNSYLVANIA HOSPITAL

Postgraduate Course—Applied Office Psychiatry: 3:00–7:00 P.M. Thursdays (12 weekly sessions); Institute of the Pennsylvania Hospital, 111 North 49th St., Philadelphia, Pa. Open to all graduate physicians. Contact: Sydney E. Pulver, MD, Course Director, The Institute of the Pennsylvania Hospital, 111 North 49th St., Philadelphia, Pennsylvania 19139.

SEPTEMBER 26, 1968-FEBRUARY 7, 1969

UNIVERSITY OF PENNSYLVANIA SCHOOL OF MEDICINE, GRADUATE DIVISION

Postgraduate Course—Medical Hypnosis: 3:00–7:00 P.M. Thursdays (20 weekly sessions); Institute of the Pennsylvania Hospital, 111 North 49th St., Philadelphia, Pa. Open to all graduate physicians. Contact: Office of the Director, Division of Graduate Medicine, 237 Medical Laboratories, University of Pennsylvania, Philadelphia, Pennsylvania 19104.

NOVEMBER 1, 1968—DEADLINE

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executive secretary's newsletter

August, 1968

ANNUAL MEETING RESOLUTIONS

Resolutions to be considered by the Faculty's House of Delegates at the Friday, September 5, 1968 Semiannual Session include the following:

Resolution 6A/68 - Participation in Maryland's Title 19 Program (Medicaid). This resolution was referred from the Faculty's Annual session to the Reference Committee for study and report to the Semiannual session.

Resolution 1S/68 - Workmen's Compensation Cases being charged on the basis of "Usual, Customary and Reasonable Fees"; and Suggesting a Course of Action in this regard.

Resolution 2S/68 - Requesting Endorsement of the Continuation of Diploma Schools of Nursing by the Faculty; importuning the AMA and the AHA to implore the National League of Nursing and ANA to encourage and support continuation of such schools, pending evaluation by qualified persons.

Copies of the above resolutions may be obtained through the Faculty office.

OCEAN CITY RESERVATIONS

Motel reservations should be made promptly for the Faculty's Semiannual Session in Ocean City, September 5, 6, 7, 1968. Full program details are in the mail to all Faculty members.

1969 SCIENTIFIC EXHIBITS

Those interested in displaying a Scientific Exhibit at the Faculty's Annual Meeting, April 9, 10, 11, 1969, should contact the chairman of the Program and Arrangements Committee, Joseph D. B. King, MD.

SURPLUS MEDICAL TEXTBOOKS

The library is in the process of clearing out its duplicate copies of various medical textbooks. Any member who wishes these surplus copies, or any individual copies, may have them for the asking.

They are available for perusal September 16 through 30, in the Faculty library. After this date they will be discarded.

DID YOU KNOW

DID YOU KNOW----

The Faculty Office maintains a complete listing of Officers of the various statewide Specialty groups.

Information is available through the Faculty on scientific programs and meetings scheduled in the State of Maryland...when you're next planning a program of interest to physicians, why not check to see if you can avoid conflict with other groups planning programs.

Officers and Committees of the Faculty never vacation from their responsibilities. During the summer months, for instance, the Legislative Council is in session and holds hearings on legislative proposals referred to it from the General Assembly and discusses ideas and suggestions for initiating legislation. Faculty representatives attend these sessions to testify.

In the meantime, preparation must proceed for Semiannual meeting arrangements; reports must be written for submission to Delegates; and the Reference Committee must hold its session to consider resolutions scheduled to come before the Semiannual, Ocean City, meeting.

FOOD FOR THOUGHT

Roger M. Blough, Chairman of the Board, United States Steel Corporation, in a speech before the American Iron and Steel Institute, says:

"...It is...time to show the relationship between healthy corporate enterprise and the indispensable role of the productive process in securing social change...Our Government administrators and legislators intelligent and faithful as they are, do not yet appear to understand that the poor are harmed and not helped by excessive social expenditures; by expenditures which use up dollars which, if not taken by taxes for that purpose, could build productive facilities to feed and clothe and house those same poor and which, most importantly, could provide them with the well-paying jobs they need."

NOT TOO EARLY

AMA Clinical Meeting, Miami Beach, December 1-4, 1968
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John Sargeant
Executive Secretary

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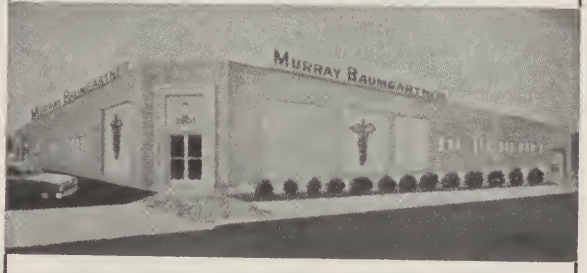




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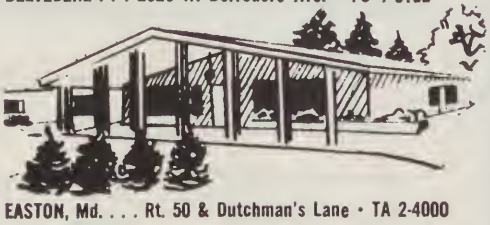
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In a five-year period beginning in 1962, over one-million cytologic examinations in hospitals throughout the United States have revealed cervical cancer in more than 6,500 according to a statistical analysis compiled by the National Center for Chronic Disease Control. More than 4,000 cases of carcinoma in situ were detected.

There are 143 projects in 35 states, the District of Columbia, and Puerto Rico. In these projects attention has been focused on low socio-economic groups because of their high risk of cervical cancer.

The Cancer Control Program also supports the American Academy of General Practice in its "office-detected cervical cancer program." More than 4,000 physicians in 36 states and the District of Columbia participate in this program which began in 1965. Over 546,000 women have had Pap smears, about one-third of them for the first time. According to the latest reports, a total of 1,059 carcinomas have been detected—865 in situ and 194 invasive.

William L. Roberson, MD, PHS medical officer, noted that the number of early cases being detected in the screening projects and subsequently cured is highly significant and "support our contention that cervical cancer can be controlled if all women will have a pelvic examination and Pap smear at least once a year."



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Baltimore County Medical Association

The June meeting of the Baltimore County Medical Association was held on June 12 at the Penn Hotel in Towson. Following a delicious luncheon, the meeting was called to order by Sidney J. Venable, MD, president.

Dr. Venable welcomed the members of the Woman's Auxiliary and introduced Mrs. Roger Windsor, the new president of the county auxiliary who introduced the new president of the Woman's Auxiliary to the Medical and Chirurgical Faculty of Maryland, Mrs. Leonard Warres.

A letter from Mrs. Edward Krieg, immediate past president of the auxiliary, was read. Mrs. Krieg thanked the association for a check sent to auxiliary for some of its projects.

In the absence of the chairman, Dr. Venable read the report from the Board of Governors. The Board met on June 5 in the Board Room of the Baltimore County Health Department. ☐ A list of delinquent dues paying members was read and the Executive Secretary was asked to call them in reference to their delinquency. ☐ The printing of a new directory was approved. ☐ The Executive Secretary asked permission to use the Baltimore County Medical Association's mailing list to contact the medical assistants in Baltimore County to see if there is enough interest to start a Medical Assistants Association in the county. This is an organization approved by the American Medical Association. Permission was granted. ☐ A letter was received from Frank Kaltreider, MD, asking the Association to reply as to how many members give to the United Appeal. On proper motion the request was denied. ☐ It was requested that all members read the Changes in the Medical Practice Act (see June issue of the JOURNAL) since they will be discussed at the August meeting and at the House of Delegates meeting of the Faculty in Ocean City in September. ☐ Dr. Venable suggested that a directory be published for our members which would include a photograph of each member and a short curriculum vitae. This request will be included with all new applications.

On proper motion, the report of the Board of Governors was accepted.

Dr. Venable introduced Mrs. Louis Dalmau, Chairman of the Nurses Scholarship Committee, who introduced the two recipients of nursing scholarships this year: Miss Vickie Franklin of Woodlawn High School and Miss Terry Hetrick of Dundalk High School.

Theodore Patterson, MD, announced the Crab Feast would be held on August 21 at Duffy's Restaurant; and the September meeting will be held at the home of J. Morris Reese, MD, at Tydings-on-the-Bay, Annapolis.

Dr. Patterson introduced Elliott Michelson, MD, who spoke on the "Pathology of Smoking." This was a most interesting and timely talk and greatly appreciated by our members.

There being no further business, the meeting was adjourned.

SAMUEL N. BACON, JR., MD
Chairman—Public Relations

Talbot County Medical Society

The Talbot County Bar Association and the Talbot County Medical Society held their annual dinner meeting at the Chesapeake Bay Yacht Club in Easton on May 17. Speaker for the occasion was Walter F. Tabler, Esq., of Baltimore, who spoke on the "Medical-Legal Code of Cooperation."

Louis S. Welty, MD, County Health Officer, was honored recently for some 30 years of service. Honoring him was a group of Talbot County friends who presented a portrait of him executed by the Easton artist, A. Brittain Banghart, to the Talbot County Health Center.

LOUIS S. WELTY, MD
Secretary

Maryland Academy of General Practice Annual Meeting Held in May

The Maryland Academy of General Practice held its annual meeting May 25–26 at the Annapolis Statler Hilton Inn, Annapolis, Maryland. The chapter celebrated its 20th Anniversary.

The scientific portion of the program was a symposium on Pediatrics. Speakers included Drs. Ephraim Lisansky, Richard S. Munford, Karl Weaver, Harry Robinson, Jr., Richard L. London of the University of Maryland School of Medicine; Murray Kappelman, Head of Nursery Section, Sinai Hospital, Baltimore; Robert Tolson, Georgetown University School of Medicine, Washington, D.C.; William Anderson, Past President of the American Academy of Pediatrics; Donald Delaney, Children's Hospital, Washington, D.C.; Robert Cooke, The Johns Hopkins Hospital; Leon Cytryn, George Washington University, Washington, D.C.; and Margaret Paxson, Planned Parenthood Association of Maryland.

The annual business meeting was held on Saturday, May 25, 1968 during which the new officers were elected. The new officers include President Leon Berube, MD, Mechanicsville; President-Elect, William Stewart, MD, Westminster; Vice Presidents Daniel Welliver, MD, of Westminster; James Jarboe, MD, of Great Mill; John Hyle, MD, of Baltimore City; Philip Heuman, MD, of Bel Air. Directors that were elected are Howard Weeks, MD, Hagerstown; George Patrick, Jr., MD, of Silver Spring; John Schaefer, MD, of Baltimore; Warren Lesch, MD, of Bel Air; Frank B. Thomas, MD, of Hancock; Fred Johnson, MD, of La Plata; John Chissell, MD, of Baltimore; and Richard Tyson, MD, of Easton. Archie Cohen, MD, of Clear Spring, and Roy Guyther, MD, of Mechanicsville were re-elected as Delegates to the AAGP with, Drs. Robert Farr of Chestertown, and Guy Reeser of St. Michaels being elected as Alternate Delegates. G. Overton Himmelwright, MD, of Cumberland, continued in his term as Secretary for the next year, along with Harry Knipp, MD, of Baltimore, as Treasurer. Mrs. Dorothy Holman was re-appointed for another year as Executive Secretary.

An overflow crowd attended the annual banquet on Saturday night with President John Ball, MD, serving as toastmaster. Charles "Mac" McC. Mathias, Jr., Member of Congress, 6th District, Maryland and now a candidate for the Senate of the U. S. Congress, was the guest speaker.



Leon Berube, MD (left), receives his badge of office from out-going president, John G. Ball, MD, during the Annual Banquet held in Annapolis.

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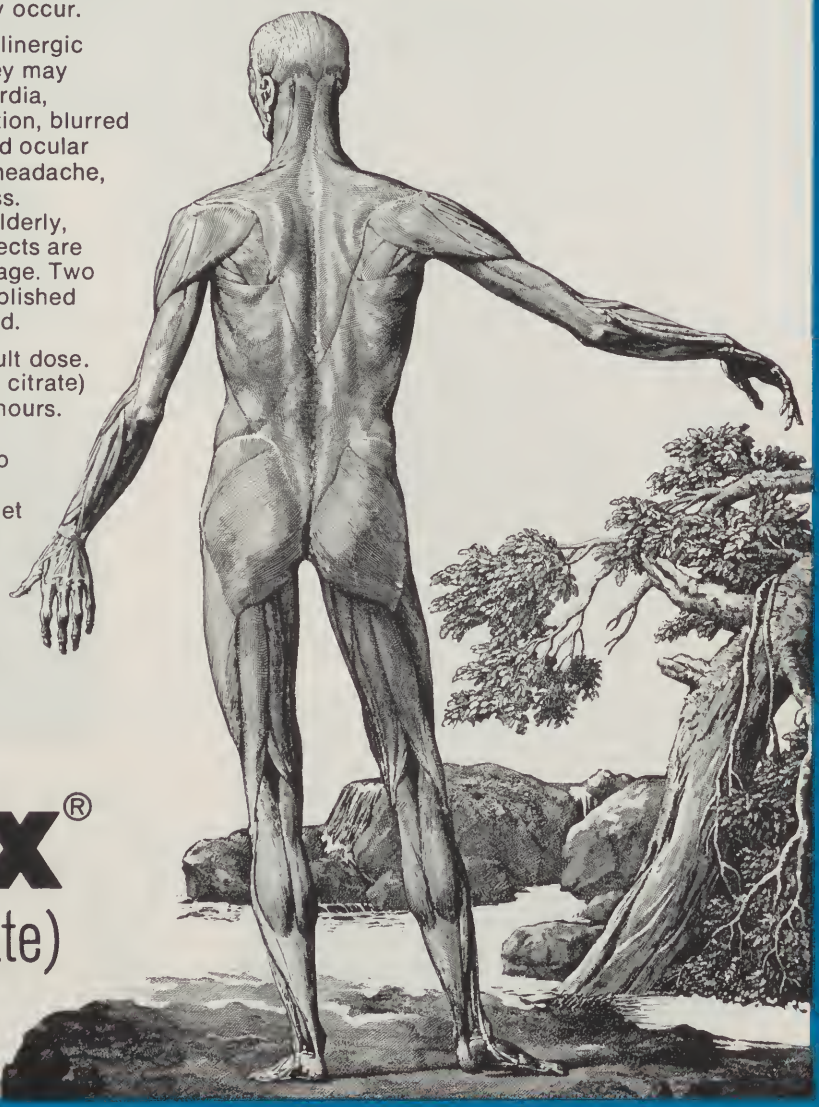
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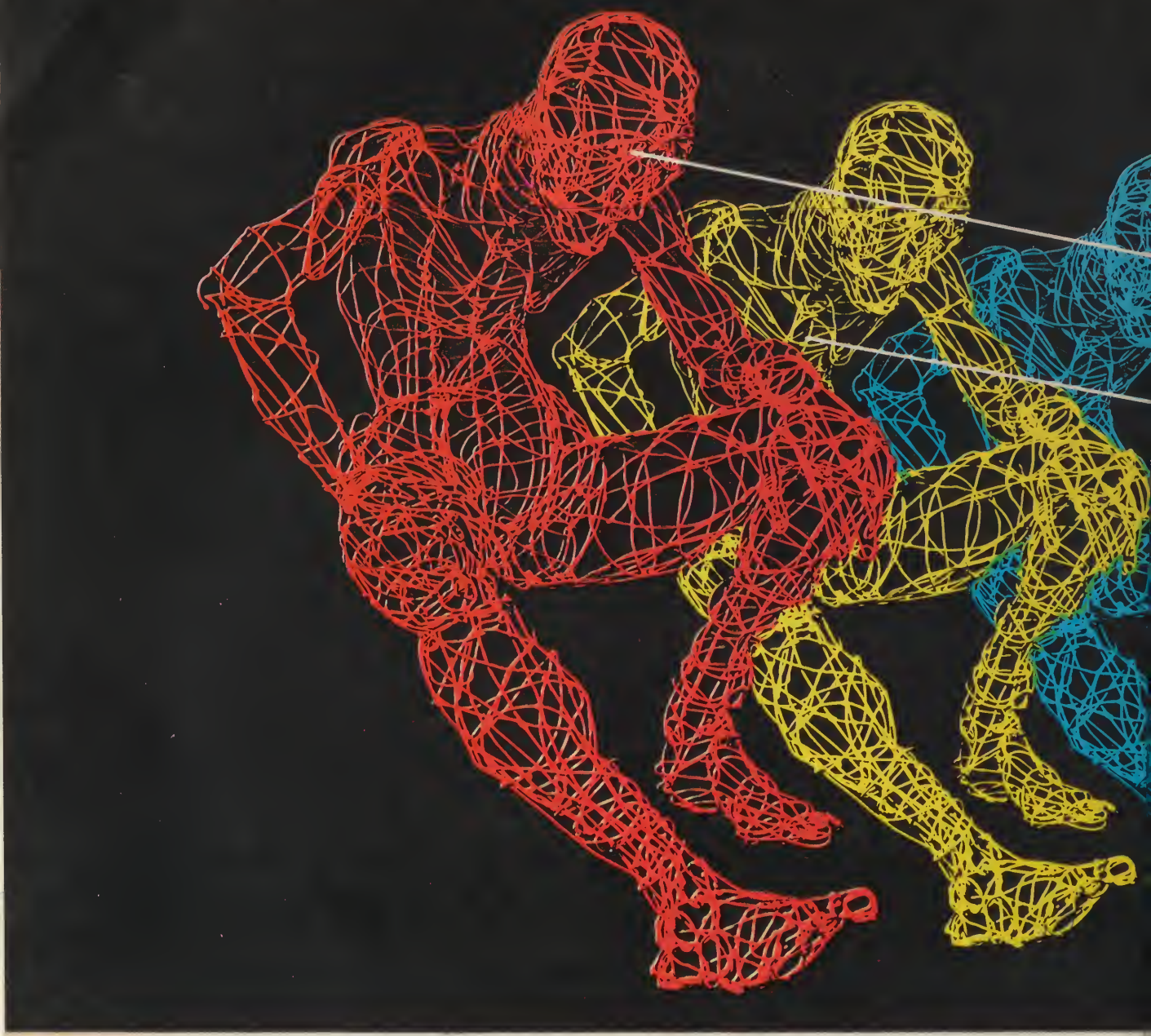
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Iron, Elemental (as Ferrous Fumarate)	110	mg.
Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

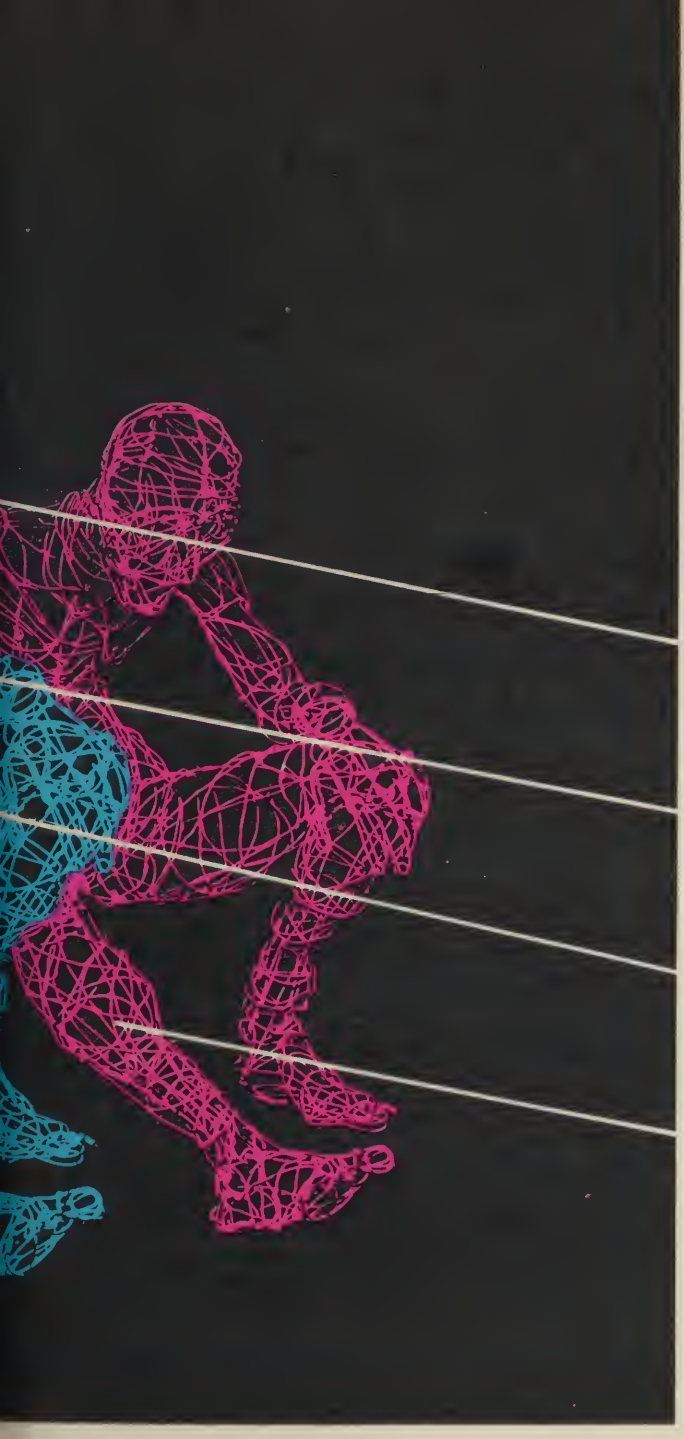
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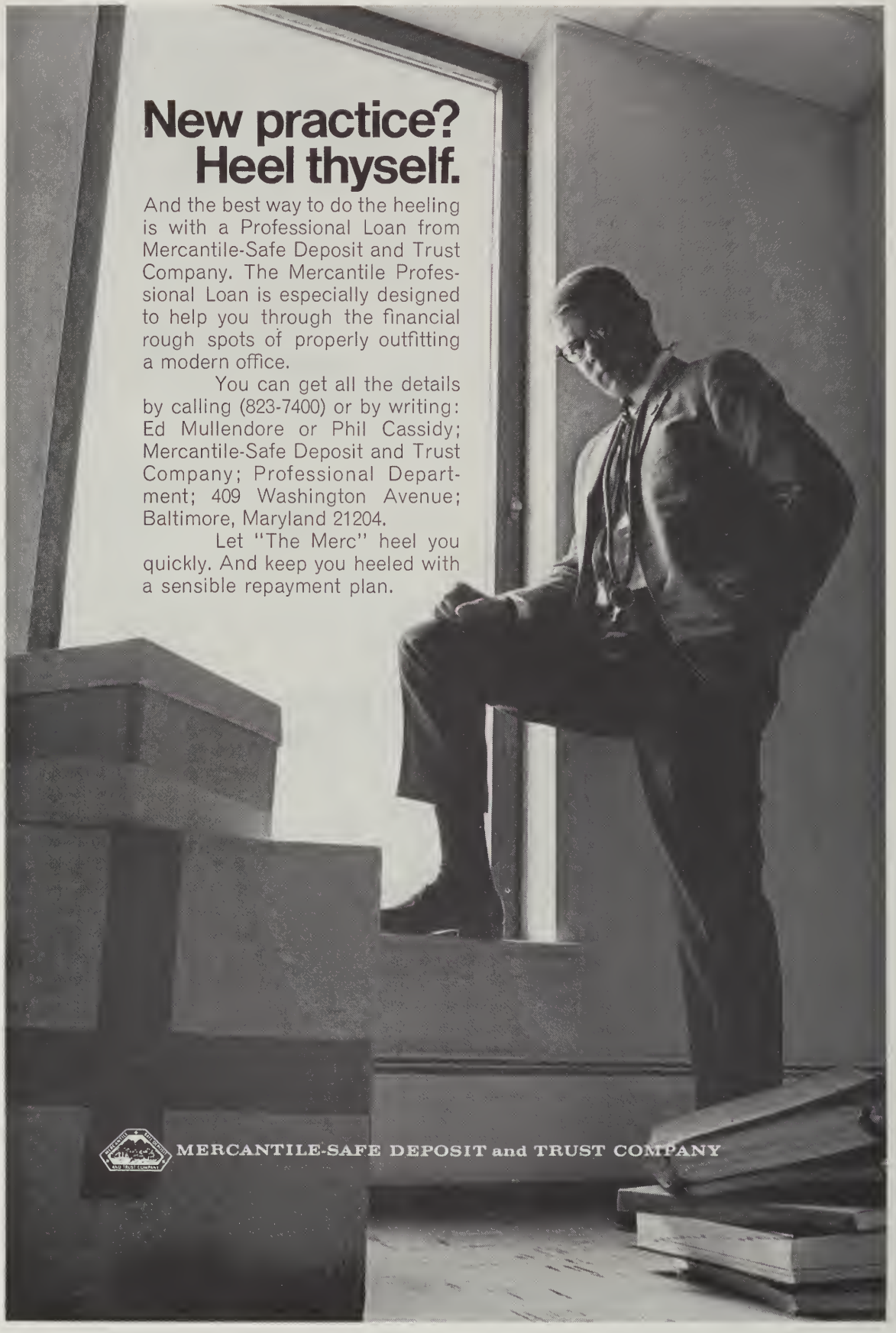
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The Culprit Behind Allergic Reactions to Poison Ivy, Oak and Sumac

The leaves of poison ivy, poison oak and sumac usually share the blame for causing an allergic rash and blisters which afflict millions of Americans during warm weather. Actually, the culprit is urushiol—an ingredient found in the sap of all three plants—according to a new folder prepared by the National Institute of Allergy and Infectious Diseases (NIAID), a division of the National Institutes of Health.

Urushiol is a potent substance affecting seven of every ten persons it touches. It causes an allergic contact dermatitis of a severity which varies with individual sensitivity and amount of exposure. As with all allergies, it is not known why some people react to urushiol while others do not.

Contact with urushiol is necessary to develop an allergic reaction. Touching a plant is the usual method of exposure. But garden tools, work clothes, roving pets, or the smoke from burning plants (especially during fall leaf-burning time) can provide indirect contact with the substance.

Most people worry about scarring—which rarely occurs—and over-treat the symptoms. Removing all urushiol from the skin and eliminating indirect contact are the most important procedures. A drying lotion usually relieves the rash and its accompanying itch, although a particularly susceptible person with a severe reaction should, of course, seek a physician's care.

The new folder also devotes a section to pointers on how to recognize, avoid, and eliminate the plants.

The NIAID is the primary research arm of the PHS concerned with allergic disorders and infectious diseases.

Single free copies of "Poison Ivy, Oak, and Sumac" Public Health Service publication No. 1723, may be obtained from the Information Office, National Institute of Allergy and Infectious Disease, Bethesda, Md. 20014. Additional copies are available from the Superintendent of Documents, U. S. Government Printing Office, Washington, D.C. 20402, at a cost of 5¢ each. Bulk orders are $3.50 for 100 copies.

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Book Reviews

THE NEONATE WITH CONGENITAL HEART DISEASE, Richard D. Rowe, MD; Ali Mehrizi, MD; The W. B. Saunders Company, Philadelphia, Pa. 1968.

Both Drs. Rowe and Mehrizi are Professors at The Johns Hopkins University School of Medicine and have worked closely in association with Alexander J. Schaffer, MD, in producing Volume V in the Series of Major Problems in Clinical Pediatrics.

In the United States, as in every country where statistical records are gathered, deaths from congenital heart disease are heavily concentrated in the first few months of the first year of life. Thus congenital malformations assume a relatively larger role in neonatal death.

In the foreword it is stated:

"There is a fairly widespread view, often regrettably encouraged by cardiologists unfamiliar with neonatal pediatrics, that the mere presence of heart disease in an ill newborn suggests an inability to survive. In this view, any child with congestive heart failure or central cyanosis is automatically considered inoperable and beyond help. The fallacy of this view lies in the fact that it is only a partial truth. There can be little question that such a clinical picture usually spells serious disease, but it does not necessarily imply inevitable disaster. On the medical side, there is presently a greater ability to treat congestive heart failure in an aggressive manner. This can improve the chances for those with serious heart disorders as well as for those with transient disturbances such as respiratory inadequacies which may exaggerate the effects of only moderately severe congenital heart disease. Disturbances of cardiac rhythm come within the same category. Correction of metabolic acidosis in the severely cyanotic infant may be an extremely valuable preliminary to operation. Surgical correction is available for patients with patent ductus arteriosus and coarctation of the aorta, and palliation is possible for

others with coarctation of the aorta complicated by left-to-right shunts, transposition of the great vessels or ventricular defects. There is little doubt that more widespread recognition of the early signs of congenital heart disease in newborn infants could lead to more effective therapy and a greater reduction in mortality. Furthermore, a greater willingness to recommend investigative procedures in infants with congenital heart disease is urgently needed to close the gap between the referring physician and the specialist-hospital team.

"This is not to imply that there are not still great areas of ignorance about cardiorespiratory adaptation and metabolic imbalance in the infant with congenital heart disease. Further support for research is needed; likewise, more attention is needed in the search for etiologic mechanisms. The effects upon the developing fetal heart and vessels of maternal rubella, thalidomide ingestion, and abnormal vitamin D-calcium homeostasis are outstanding examples of recent areas of investigation.

"A long association with neonatal cardiologic problems does not necessarily guarantee an ability to emerge from consultation with correct, let alone consistently correct, recommendations. It does, however, engender awareness of the tremendous problems involved in treating this age group, a recognition of human fallibility in clinical judgment and a real sense of humility in dealing with afflicted infants and their parents. It is because of our conviction that the fetal and neonatal periods are of vital importance in the study of heart disease in children that we have the temerity to attempt this task. It has not been our aim to make this monograph an encyclopedia containing all possible presentations of congenital heart malformation in newborn infants. Rather, it is meant to reflect our experience with the most regularly encountered malformations and to touch meaningfully on the most important of the rarer malformations. We appreciate that our colleagues in pediatric cardiology will quickly recognize flaws in this approach and that some may be displeased by omission of reference to favorite publications. Yet we hope that the portrayal of the subject by pediatricians with interests in morbid anatomy and hemodynamics may have sufficient seasoning through clinical orientation and experience to be helpful to those who have to be concerned with the care of the very young."

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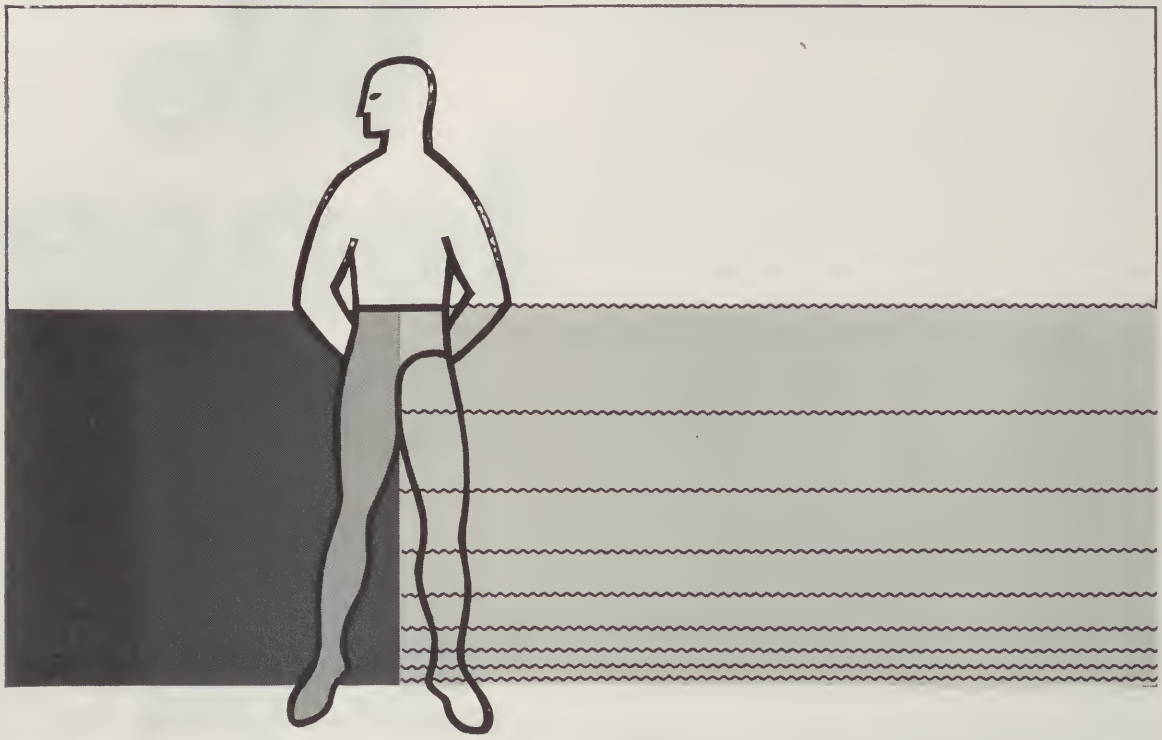
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Maryland Association of Medical Assistants

Edward F. Wilson, MD, speaks to Baltimore Association of Medical Assistants

The monthly meeting of the Baltimore Association of Medical Assistants was held on Tuesday, June 11, at Velleggia's Restaurant. Cocktails were served at 6:30 P.M. with dinner following at 7 P.M.

Edward F. Wilson, MD, was guest speaker for the evening. Dr. Wilson spoke on "The Black Hole of Calcutta." His topic proved to be very intriguing and interesting. He told of an incident at Fort William, India, in 1756, when the Nabob's Army repelled the British East India Company forces in Bengal, and 146 people were imprisoned in the "Black Hole."

Dr. Wilson described the physical aspects of their imprisonment in relation to the dimensions of the "hole." When the prisoners were released, only 23 survived, and the remaining 123 died as a result of asphyxia due to compression and carbon monoxide intoxication.

Dr. Wilson was born in Springfield, Ohio. He was graduated from high school in Tarrytown, New York, and after attending Cornell University went to Pennsylvania University and received his BS degree. He was graduated from Yale University Medical School and served his internship and residency in Pathology at The Johns Hopkins Hospital; and Memorial Hospital for Cancer and Allied Diseases in New York. Since 1967, Dr. Wilson has been Assistant Medical Examiner for the State of Maryland.



Edward F. Wilson, MD, was guest speaker at the June meeting of the Baltimore Association of Medical Assistants.



Connie Galton (left), Assistant to the Executive Secretary of Med-Chi, with Eleanor Mainhart, President of BAMA, during the Medical Assistants' Seminar.

(continued on next page)

MAMA Members attend "Medical Assistants' Seminar"'

Members of the Maryland Association of Medical Assistants attended the "Medical Assistants' Seminar" held at the Sheraton-Belvedere on Thursday, June 13. The seminar was sponsored by the Medical and Chirurgical Faculty of Maryland, and was held from 10 A.M. to 4 P.M.

Many of the medical assistants found the lectures very helpful in conjunction with the AAMA certification examination held at the end of June. Especially informative were the discussions on the Medicare Program by Mr. John Webb, Medicaid by Mr. John Morris, and Office Do's and Don't's from a Legal Standpoint by John King, Esquire.



Robert Goldstein, MD, is pictured with members of the Maryland Association of Medical Assistants during the Seminar. From left: Rita Cobry, Eleanor Mainhart, and Dorothy Walker, Treasurer of the Baltimore chapter.

Montgomery Chapter of MAMA Holds Educational Symposium

The Montgomery Association of Medical Assistants held an educational symposium on Sunday, June 23, at the Sheraton-Silver Spring. The program commenced at 12:30 with a luncheon.

At 1.45 P.M. Miss Sandra Orrison, President of the Montgomery Association, delivered a welcoming address. Samuel M. Fox, III, MD, Chief of the Heart Disease and Stroke Control Program of the Public Health Service was the first speaker, and his topic was "Mobile Coronary Care Units." Miss Barbara Ceibelt, RN, Nursing Supervisor, CCU, Holy Cross Hospital, Silver Spring, Md., then spoke on "The Cardiac Patient and the Coronary Care Unit." "Spare Parts For Human Hearts" was then presented by William S. Lyons, MD, Clinical Instructor in Thoracic Surgery at the Georgetown University Medical School. The final speaker of the day was Walter M. Jarvis, MD, Psychiatrist, Chestnut Lodge, Rockville. Dr. Jarvis spoke on "Problems Encountered by the Post-Coronary Patient."

Following the speakers' presentations which included slides on the various subjects, there was a question and answer period.

PEGGY BURY
Journal Correspondent



Pages 31-38 missing

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ACS Regents Act On Surgical Education, Hospital Relations, Rehabilitation

Acting on a request by representatives of surgical specialty Boards, the American College of Surgeons Board of Regents has approved in principle the development of a College-sponsored workshop to consider the core of knowledge which might be incorporated into the early years of residency programs for all surgeons. The workshop will also attempt to determine the mechanism for acquiring and evaluating by examination this core of knowledge.

Meeting at College headquarters June 7–9, the Regents also approved the funding of a workshop designed to improve relations and communication between surgeons, hospital administrators, and hospital governing boards. The workshop will be co-sponsored by the American Hospital Association.

Also, they approved the development of an educational program to improve the rehabilitation of the geriatric amputee. An ad-hoc committee under the chairmanship of Richard Warren, MD, Boston, will be responsible for the project.

In other actions, the Board of Regents:

—Established an Advisory Committee on Nominations consisting of James T. Priestley, MD, Rochester (chairman); Howard A. Patterson, MD, New York, and Walter C. MacKenzie, MD, Edmonton, Canada. The committee will assist the nominating committees of the Board of Governors and of the Fellows.

—Rescinded an existing regulation reducing to $25 the Fellowship fee for an initiate who is (1) employed by a medical school or affiliated institution in full-time research or teaching; and (2) receives no professional income from other sources; and (3) graduated from medical school not more than 12 years prior to the time he is admitted to Fellowship. The action will become effective with the class of 1969.

Originally, the purpose of this reduction in the Fellowship fee was to ease the financial obligation of Fellowship for initiates who were at the beginning of their academic career, were paid low salaries, and derived no income from practice. Today, however, most young initiates have appointments as assistant professors, or better, and even those who hold lower appointments are able to earn an additional income from practice.

—Voted to appoint Claude E. Welch, MD, Boston, chairman of the 1969 Clinical Congress program committee, effective July 1, 1968. He succeeds William P. Longmire, Jr., MD, Los Angeles.

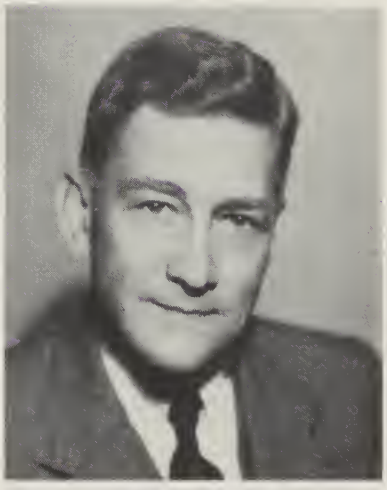
—Approved the election by the Forum Committee of David C. Sabiston, Jr., MD, Durham, as new Committee chairman, and William R. Drucker, MD, Toronto, as chairman-elect. Both will begin their three-year term of service at the close of the 1968 Clinical Congress.

—Selected for its 1969 meetings the dates of February 7–9 and June 13–15, and for its adjourned meeting (following the 1969 Clinical Congress in San Francisco) the date of October 10. The Board will also meet during the three days preceding the Congress.

MEDICAL NEWS



Russell S. Fisher, MD, President-Elect of the Medical and Chirurgical Faculty, is given a handshake by Governor Spiro T. Agnew on the occasion of the signing of House Bill 21 establishing a Commission on Medical Discipline. At left is Marvin Mandel, Speaker of the House. In the background is Aris T. Allen, MD, the only physician Representative in the General Assembly.



Dr. Howard

John Eager Howard, MD, Professor of Medicine at The Johns Hopkins University School of Medicine, was recipient of the **Passano Foundation Award** presented during the annual meeting of American Medical Association held in San Francisco in June.

Dr. Howard was selected to receive the yearly $5,000 award for his outstanding contributions in medicine, especially for his studies of calcium metabolism. He has identified a substance in blood and urine which keeps calcium in solution. A lack of this substance may be of significance in the causation of kidney stones.

Dr. Howard has made many other discoveries during his career. He has shown that excess amounts of Vitamin D cause elevated levels of blood calcium resulting in damage to health. He first described unilateral renal disease as a cause of high blood pressure and discovered that removal of the diseased kidney or restoration of its blood supply returns blood pressure to normal.

A native of Baltimore, Dr. Howard received his undergraduate degree from Princeton University

in 1924, and his MD degree from The Johns Hopkins University in 1928. From 1928 through 1934 he occupied positions as house officer and research fellow at Massachusetts General Hospital and at The Johns Hopkins Hospital. Since 1934, Dr. Howard has been a member of the faculty of The Johns Hopkins University School of Medicine. In addition to his Staff position at The Johns Hopkins Hospital, he is also Chief of Medicine at Union Memorial Hospital.

* * *

Glendon E. Rayson, MD, of Baltimore has been serving in Viet Nam under the auspices of the AMA Volunteer Program to aid Vietnamese civilians.

Dr. Rayson is currently a research associate in the Department of Chronic Disease, The Johns Hopkins School of Hygiene and Public Health.

* * *

The new acting State Commissioner of Mental Hygiene is **James E. Carson, MD.** He is successor to **Isadore Tuerk, MD,** who retired last month.

Dr. Carson has been Deputy Commissioner of the Department of Mental Hygiene since 1962.

* * *

Eli Breger, MD, of Cockeysville has been elected a Fellow of the American Academy of Pediatrics and the American Academy of Child Psychiatry.

* * *

Louis Sachs, MD, co-founder of the Baltimore County General Hospital, has been cited by the hospital's Board of Trustees for his role in the building of the Department of Surgery.

Now Surgeon-in-Chief Emeritus, Dr. Sachs has been succeeded by **Howard H. Patt, MD.**

* * *

William S. Stone, MD, dean of the University of Maryland School of Medicine, was honored at a testimonial banquet in May given by the faculty and friends of the school.

June marked the completion of a decade and a half of academic and administrative services for Dr. Stone.

In reviewing Dr. Stone's contributions to the medical school, Wilson H. Elkins, PhD, president of the university said, "Five years from now the physical plant of the School of Medicine will be developed to the extent of providing for the growing needs of medical education. It will be an imposing complex . . . It will bear the mark of his vision, dedication and hard work.

"It has been said on many occasions and by many people that the first qualification of a good doctor is to be a good man—that is, a man of integrity, broad vision, compassion, and moral strength. If that is true, as it surely is, then a dean of a medical school must have the same qualities in even greater abundance. These are the qualities that I have admired in Dr. Stone during his 15 years with the university."



Dr. Stone

* * *

The first medical school to join the Alliance for Progress Partnership Program is the **University of Maryland School of Medicine.**

During the summer, three students from the University visited Brazil in an exchange fellowship program sponsored by the Maryland Partners of the Alliance for Progress. **George Entwisle, MD,** Professor and Chairman of the medical school's Department of Preventive Medicine and Rehabilitation, and **Matthew Tayback, MD,** Deputy Health Commissioner for Baltimore and

Chairman of the Maryland Partnership's Health Committee, made the arrangements for the exchange program at the Federal University of Niteroi, the capital and largest city of Rio de Janeiro, a subdivision of Brazil—Maryland's South American partner.

Janet Mules, MD, a fellow in the Department of Preventive Medicine and Rehabilitation, supervised the students in making a field survey of infant health problems in rural areas.

* * *

George Z. Williams, MD, Chief of the Clinical Pathology Department, Clinical Center, National Institutes of Health, was awarded an honorary Doctor of Science degree from the University of Colorado in June.

The citation commended Dr. Williams for his ". . . important contributions to the scientific development of medicine in this century," and for his "major role in bringing the discipline of laboratory medicine to the position of eminence that it holds today, and paving much of the road that it must take tomorrow."

An internationally renowned pathologist, Dr. Williams' studies of biochemical profiles in normal persons have stimulated widespread interest and broadening investigation, with promising potential for early recognition of disease processes and new approaches to preventive medicine. His research in experimental cancer pathology and his study of cell chemistry by ultra-violet microscopy, together with his other studies, have led to many useful contributions to the literature of his profession.

Dr. Williams earned his MD degree from the University of Colorado. Among other honors accorded him during his distinguished career are The Ward Burdick Award, American Society of Clinical Pathologists (1961); Superior Service Award, Department of Health, Education and Welfare (1964); and the Distinguished Service Award, DHEW (1965).

* * *

The President of the Heart Association of Western Maryland, **Richard A. Young, MD,** of Hagerstown, spoke on "Pediatrics" during the "Weekend with Doctors" held at Frostburg State College in June. The program was sponsored by the Heart Association of Western Maryland.

* * *

John B. Dunbar, DDS, has been appointed Chief, Program Projects Branch, Extramural Programs, National Heart Institute. Since October, Dr. Dunbar has been Program Director for the Health Sciences Advancement Award Program, General Research Support Branch, Division of Research Facilities and Resources, NIH.

As Chief of the Program Projects Branch, Dr. Dunbar will be responsible for directing the Institute's research grants program in support of broadly based, long-term programs of cardiovascular research. These grants provide the administrative flexibility needed to enable scientists from separate departments and laboratories to pool their specialized talents for an interdisciplinary attack on particular research problems. Typically, the grants support clinical facilities for the study of research patients as well as the usual items supported by regular research project grants. The Heart Institute has awarded Program Project grants since 1961.

* * *

On July 1st, **Jerome S. Harris, MD,** took over as Chief of the Department of Obstetrics and Gynecology at Sinai Hospital.

Dr. Harris succeeds **Joseph Seitchik, MD,** who resigned to become Professor and Chairman of the Department of Obstetrics and Gynecology at the University of Texas School of Medicine in San Antonio.

Prior to his appointment, Dr. Harris served as Associate Clinical Professor of Obstetrics and Gynecology at the University of Colorado Medical School.

* * *

The appointment of **Charlotte Silverman, MD,** as Chief of the Population Studies Program of the U. S. Public Health Service, National Center for Radiological Health, has been announced.

Dr. Silverman, former Deputy Chief of the program, is the first woman to head a Center program. She has been associated with the Public Health Service for nine years and joined the Center staff in January of this year. Dr. Silverman had been with the National Institute of Mental Health and her assignments there included Medical Officer in the Division of Field Investigations, and Chief of the Epidemiologic Studies Branch.

The Month in Washington

President Johnson designated the Secretary of Health, Education and Welfare, Wilbur J. Cohen, as the chief federal official for health policies and programs.

An HEW reorganization plan, recommended by Cohen and approved by Mr. Johnson, makes the secretary:

- ☐ The President's chief adviser on federal health policy and programs.
- ☐ Responsible for coordinating all federal health programs.
- ☐ Head of a new Federal Interdepartmental Health Policy Council.

The reorganization also included creation of a Consumer Protection and Environmental Health Service as a unit of the Public Health Service and transfer of the Division of Regional Medical Programs from the National Institutes of Health to the Health Services and Mental Health Administration.

Mr. Johnson also agreed to renew a request to Congress to raise the status of HEW's principal health official, now **Philip R. Lee, MD,** from Assistant Secretary to Under Secretary for Health and Science.

The new consumer and environmental health unit consists of:

—The Food and Drug Administration;
—The National Center for Air Pollution Control;
—The National Center for Radiological Health;
—The National Center for Urban and Industrial Health;
—Certain staff units of the Office of the Director, Bureau of Disease Prevention and Environmental Control.

Charles C. Johnson, Jr., a Negro and Assistant Commissioner for Environmental Health in New York City, was named to head the new unit. An engineer, he had been on leave from the Public Health Service and his new post makes him the highest ranking Negro in the history of PHS.

Herbert L. Ley, Jr., MD, who had been director of the FDA's Bureau of Medicine since the fall of 1966, was appointed to succeed James L. Goddard, MD, who recently resigned as Commissioner of Food and Drugs. Dr. Ley, 44, had been recommended by Goddard and also had the support of a number of Senate and House members on committees concerned with FDA. A 1946 graduate of the Harvard Medical School, Dr. Ley had been on the faculty at his alma mater and the George Washington University School of Medicine earlier in his career. He also served as chief of medical branches of the Army research office and the office of the Army Surgeon General.

The interdepartmental health policy council will oversee all federal activities in the health field, such as the drafting of physicians for service with the armed forces, Veterans Administration hospitals and Office of Economic Opportunity health projects.

Cohen said that there had been no way in the past for the HEW secretary to give guidance in such matters. He said there must be a re-examination of the drafting of physicians to provide care in the United States for civilian dependents of military personnel.

"This allocation of a portion of the critically scarce physician pool materially affects programs intended to make health care as widely available as possible, a national health goal that goes far beyond the mission of the Department of Defense," Cohen said.

* * * * * * * * *

As medicare went into its third year, Cohen

announced the appointment of a 12-member advisory council to study the possible extension of the program to disabled persons under age 65. Congress last year turned down the Administration's request for such an extension but authorized creation of the council to study the matter.

In discussing medicare, Cohen said rising health care costs had made financing of the program a serious problem. He said new financing, presumably a tax increase, may be required if costs continue to rise.

"Physicians must act with restraint on fees or people will ask government to put on controls," he said. "I would not like to see that."

Henry H. Kessler, MD, director of the Kessler Institute for Rehabilitation in Newark, N.J., was named chairman of the advisory council. Other members are:

Morris Brand, MD, medical director of the Sidney Hillman Health Center; James Brindle, president of the Health Insurance Plan of Greater New York; James M. Gillen, director of personnel research of General Motors; Juanita Kreps, associate professor of economics at Duke University; Leonard W. Larson, MD, past president of the American Medical Association; Daniel W. Pattengill, vice president of Aetna Life and Casualty Co., Bert Seidman, director of the AFL-CIO social security department; E. A. Vaughn, vice president of the Aluminum Co. of America; Anthony G. Weinlein, executive assistant to the president of the AFL-CIO Building Service Employes; E. B. Whitten, executive Director of the National Rehabilitation Assn., and Alonzo S. Yerby, MD, professor at Harvard's School of Public Health.

* * * * * * * * *

The American Medical Association told Congress it supported most provisions of the Administration's health manpower bill as essential to increasing enrollment in the nation's medical schools.

The AMA position was outlined by William A. Sodeman, MD, of the AMA's Council on Medical Education in testimony before the House Public Health and Welfare Subcommittee. He noted that a recent joint statement of the AMA and the Association of American Medical Colleges said that more funds from both government and private sources would be needed by medical schools if they were to expand enrollment.

"The bill (H.R. 15757) before the subcommittee provides a means of furnishing the Federal component of the necessary financial resources," Dr. Sodeman said.

In other testimony, the AMA supported the overall objectives of the Administration's occupational health bill. But the Association opposed a provision that would authorize establishment and enforcement of mandatory national standards for health and safety.

R. Lomax Wells, MD, chairman of the AMA's Council on Occupational Health, told a Senate Labor Subcommittee, that the objectives of the bill (S. 2864) could "best be accomplished through the research, education and training provisions and through grants to states to enable them to undertake and conduct more effective programs in both occupational health and safety."

Urging rejection of the mandatory standards provision, Dr. Wells said that this authority has been "properly vested in the states where the standards and the enforcement can be adapted to their particular geographical and industrial conditions."

* * * * * * * * *

The U.S. Supreme Court refused, by a five to four division, to lay down a constitutional rule against punishing chronic alcoholics for being drunk in public.

In an opinion by Justice Thurgood Marshall, four members of the Court said that neither the facts of the test case nor "the comparatively primitive state" of scientific knowledge on the subject justifies such a decision at present.

The vote of the four, plus Justice Byron R. White, who concurred separately, upheld the conviction of Leroy Powell, 67, who was fined $50 in a Travis County, Texas, court for being drunk in public.

The argument for Powell was that alcoholism is a disease and the person suffering from it should be treated rather than punished.

Two AMA authorities on alcoholism expressed surprise and disappointment at the court's decision. Marvin Block, MD, of Buffalo, N.Y., a member and former chairman of the AMA's Committee on Alcoholism and Drug Abuse, and Dana L. Farnsworth, MD, of Harvard University, chairman of the AMA Council on Mental Health, took issue with the court opinion that "we are unable to conclude . . . that chronic alcoholics in general . . . suffer from such an irresistible compulsion to drink and get drunk in public that they are utterly unable to control their performance. . . ."



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Indication — For oral contraception.

Contraindications — Thrombophlebitis or a history of thrombophlebitis or pulmonary embolism, liver dysfunction or disease, known or suspected carcinoma of the breasts or genital organs and undiagnosed vaginal bleeding.

Warnings — Discontinue medication pending examination if sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine occurs. Discontinue if papilledema or retinal vascular lesions occur. Since the safety of Ovulen in pregnancy has not been established, rule out pregnancy before a patient who has missed two consecutive menstrual periods continues the tablets. Consider the possibility of pregnancy at the first missed withdrawal flow if the recommended schedule has not been followed. The active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this to the infant has not been determined.

Precautions — The pretreatment physical examination should specifically include the breasts, pelvic organs and a Papanicolaou smear. Endocrine and possibly liver function tests may be affected by Ovulen. Such tests should be repeated two months after stopping the medication if their results were abnormal in a woman taking Ovulen. Pre-existing fibroids may enlarge under the influence of progestin-estrogen preparations. Patients with epilepsy, migraine, asthma, cardiac or renal dysfunction, which conditions might be influenced, require careful observation because Ovulen may cause some degree of fluid retention.

Ovulen should be used with caution in patients with a history of cerebrovascular accident. Nonfunctional causes should be considered if breakthrough bleeding occurs. Adequate diagnostic measures are indicated in women with undiagnosed vaginal bleeding. Carefully observe patients with a history of psychic depression and discontinue the medication if depression recurs to a serious degree. Any possible influence of prolonged Ovulen use on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. Carefully observe diabetic patients during Ovulen use since a decrease in glucose tolerance has occurred in a few such patients. Physicians should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism since such conditions occasionally occur in patients taking oral contraceptives. Use Ovulen judiciously in young patients in whom bone growth is not complete because of the effects of estrogens on epiphyseal closure. Age is no absolute limiting factor, although Ovulen use may mask the onset of the climacteric. Pathologists should be informed of Ovulen use when relevant specimens are submitted.

Side effects — The following adverse reactions have been observed in varying incidence in patients taking oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosions and secretions, suppression of lactation when used immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals and mental depression.

Although the following side effects have been reported in users of oral contraceptives no cause and effect relationship has been established: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption and itching. Thrombophlebitis, pulmonary embolism and neuro-ocular lesions have occurred in users of oral contraceptives, although a cause and effect relationship has been neither established nor disproved.

The following laboratory results may be altered by oral contraceptives: Bromsulphalein® and other hepatic function tests—increased; coagulation tests, including prothrombin, Factors VII, VIII, IX and X — increased; thyroid function — increase in protein-bound iodine and butanol extractable protein-bound iodine, and a decrease in T^3 values; metyrapone test and pregnanediol determinations.

Dosage and administration — One tablet of Ovulen-21 daily for 21 consecutive days, beginning five days after the onset of a menstrual flow (the first day of menstruation is counted as day 1), then discontinued for one week. If Ovulen is started later than day 5 after menses begins another method of protection is used until the first seven tablets have been taken. Subsequent 21-day courses are begun on the eighth day after the last tablet was taken in the preceding cycle. This three weeks on — one week off schedule is continued whether or not withdrawal flow has begun, flow has ceased or spotting or breakthrough bleeding has been experienced.

If one tablet is missed it is to be taken as soon as it is remembered and the next tablet at the usual time. If two consecutive tablets are missed the dosage is doubled for the next two days, then the regular schedule is resumed. If three consecutive tablets are missed a new tablet cycle is started on the eighth day after the last tablet was taken. For the best protection in the latter two instances instruct the patient to use another method of contraception until the next seven consecutive tablets have been taken. The possibility of ovulation increases with each successive tablet missed.

Postpartum administration — Non-nursing mothers may begin Ovulen immediately after delivery and nursing mothers after lactation is well established.

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Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

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WHY A PEDIATRICS SYMPOSIUM?

AS in other groups with a wide range of interests, the Maryland Academy of General Practice faces a problem in planning a medical meeting. Which specialty, sign, symptom or system should be selected as the theme? Sometimes having too many alternatives makes the decision difficult.

This year, the Academy selected pediatrics—a field almost as broad as family practice and one that involves almost every physician, whether he engages in research, practice or academic affairs. Since pediatrics, along with internal medicine, comprises the basic ingredients of family practice, though not the spice and leavening, it is a field in which Academy members have great interest.

Delivery of medical care is foremost in the minds of general practitioners. Therefore, learning about certain aspects of pediatrics, which enable us to deliver more and better care to patients and their families, was the principle objective of this symposium. In our context, the delivery of medical care includes the prevention of illness. Perhaps preventive medicine should be looked upon as medicine in its highest form and our ultimate objective.

Ironically, care of the baby when it is in fetal development is entrusted to someone not specializing in pediatrics. Does it follow that good maternal management is necessarily good fetal management? Physicians, being physicians first and specialists second, recognize this incongruity for what it is.

THE symposium's approach to pediatrics began with a discussion of genetic counseling and care of the infant in utero. It followed along in time sequence through the newborn, neonate, infant, and pre-school periods. Certain illnesses, signs and symptoms encountered as they criss-cross through these time periods were then discussed. Special emphasis was placed on the emotional problems of children and on an outline for a program of sex education. Both of these topics are important areas in which most physicians need additional information and insight.

Considerable material was covered in eight hours. Even so, the symposium barely scratched the surface of the volume of medicine germane to pediatrics. If the discussions provided the stimulus for more reading and self-education and a heightened sense of awareness of the problems, the meeting will have been an unqualified success.

Today, there is a great ferment in medical circles concerning primary patient care. It has become apparent that the individual patient has been treated indifferently by medical progress. In some ways this may be more suggestive than real, since all patients are able to receive technically competent medical attention. Yet is this all that man is entitled to expect?

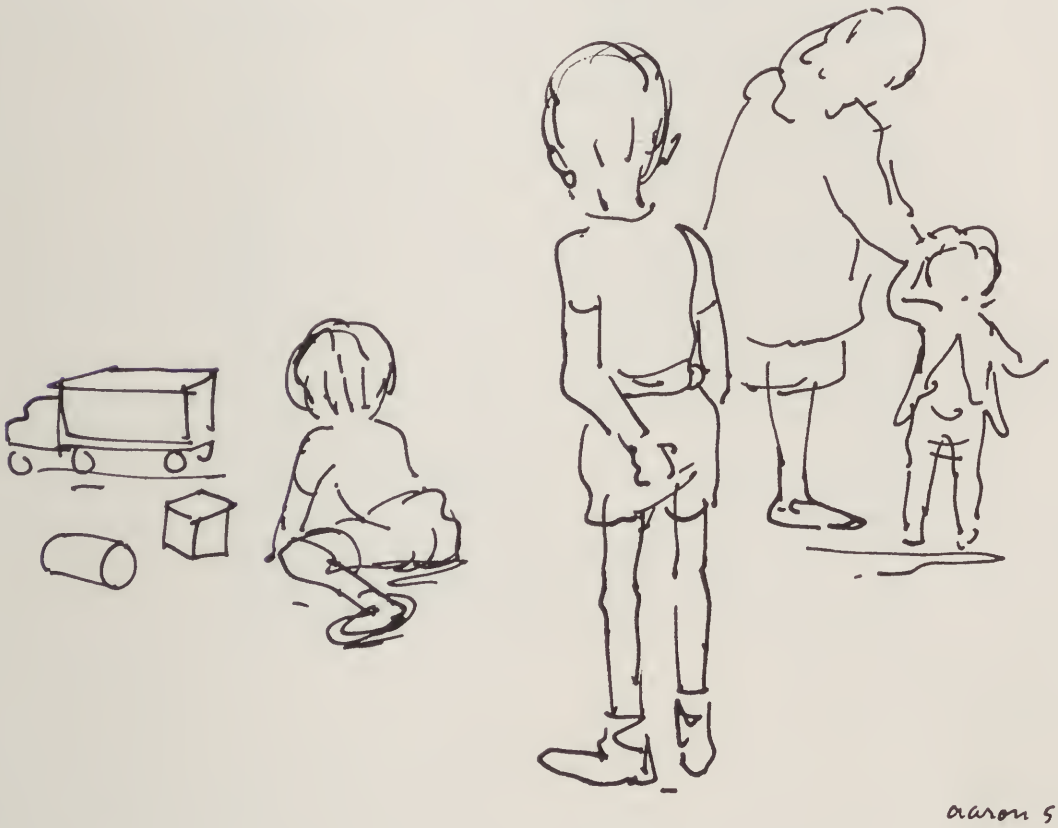
The personal touch, human identification, knowledge of the person, his family and his problems mean so much; yet modern life tends to make all of us and our problems just so many holes in a computer punch card. Hopefully this renaissance in the primary physician concept of medical care will restore some of man's lost individual identity while, at the same time, promoting the technical advances necessary for optimal care. The strengths and weaknesses of different forms under which primary medical care can be provided are matters for continued study and experimentation. Certainly there is more than one approach worth considering and investigating; no single group has the corner on wisdom. It is in this spirit that the members of the Maryland Academy of General Practice welcome the involvement of all other physicians interested in providing personalized primary medical care.

THE adage "when you want a job to be done, ask a busy man" has been confirmed. Our speakers, all busy physicians, gave generously of themselves to provide a quality symposium and to furnish material for this issue of the *Maryland State Medical Journal.*

The drug firms, Roche Laboratories and Merck, Sharp and Dohme, financed the meeting. The manner in which these companies provided funds was gracious and generous indeed. Support was given without asking anything in return. Unfortunately, the contributions of drug firms, such as these, to medical progress and to the health of all people is generally not appreciated.

LEON W. BERUBE, MD
President
Maryland Academy of General Practice

The following papers were presented during the 20th Annual Meeting of the Maryland Academy of General Practice, May 25 and 26, 1968, Annapolis.



CARE OF THE

RICHARD S. MUNFORD, MD
Associate Professor, Obstetrics & Gynecology
University of Maryland School of Medicine

There is a growing awareness of the physician's responsibility to insure the health of newborns by minimizing accidents of heredity and hazards of the intrauterine environment. Some risks of the reproductive process will probably never be completely eliminated and many will be circumvented only by the application of knowledge yet to be gained. The reproductive process may never be made completely risk free, but it may be made reasonably free through the application of experience already in hand.

Even under the most favorable circumstances, most women register for prenatal care after the first six to eight weeks of gestation have already elapsed. A critical period of intrauterine development, during which the mechanisms of growth and differentiation of the embryo and early fetus are particularly vulnerable to damage by certain environmental agents, has run its course without specific medical supervision. If these mechanisms have already been deranged by exposure to such agents, no conceivable amount of subsequent prenatal care, as traditionally defined, can alter the course of that abnormal development. Environmental agents which have been incriminated include drugs, viruses and ionizing radiation; the circumstances that surround exposure to each of these could be examined to advantage.

NFANT IN UTERO

Intrauterine Exposure to Drugs

In our over-medicated society ample opportunity exists for unnecessary exposure of the embryo and fetus to drugs. A few chemicals are known to be teratogenic in man (thalidomide and amethopterin, for example) and still others (corticosteroids and meclizine) have had demonstrated adverse effects on the embryos of lower animals. Recent reports of chromatid breaks in the cells of the offspring of parents who had ingested LSD have made us face the possibility that ingestion of some drugs prior to conception may have adverse effects on the germ cells of the male and female gonads. While the pitfalls of transferring information gained in one animal species to those of another are appreciated, the impossibility of ruling out potentially harmful effects of a drug on the human embryo and fetus must equally be recognized. Adoption of an ultra-conservative attitude toward drug administration to females who are potential mothers would seem wise. Since the thalidomide disaster, obstetricians have become perceptibly more conservative about drug administration for relatively minor symptoms and complaints. But what control does the obstetrician have over self-medication of a woman who may not even recognize she is pregnant in a society whose household medicine cabinets bulge with headache remedies, tranquilizers, diet pills, sleeping potions and the like?

It is unrealistic to expect that physicians and their patients who are potential mothers can soon be educated to avoid all but essential medication except during that portion of the menstrual cycle when absence of an unsuspected, early conception can be assumed. For complete safety this would include only the ten days following the onset of a normal menstrual period. But is it asking too much of each physician that he consider the possibility of early pregnancy in his patients and avoid dispensing medication for minor complaints whenever early pregnancy is suspected? Perhaps the only realistic hope for future elimination of this totally unnecessary risk to our unborn lies in an intensive, educational program designed to cultivate an aversion toward self-medication in our children and a more conservative attitude toward drug administration in our medical students.

Exposure to Virus Infections

Although a number of maternal, viral infections occurring in the first trimester of pregnancy (mumps, influenza, for example) have been suspected of causing damage to the growing fetus, solid evidence for a cause and effect relationship exists only for rubella. Nevertheless, in the absence of solid evidence to the contrary, immunizations utilizing live virus preparations are best withheld during pregnancy except during epidemics of serious disease (smallpox, for example).

In epidemics of rubella an estimated 5% of pregnant women become infected in the first 13 weeks of their gestation. As a consequence, almost 50% of these pregnancies will be associated with abortion, stillbirth or neonatal death with an estimated 20–25% of the infants being born alive with serious, developmental anomalies. Here again, prenatal care, as traditionally defined, fails us. The maternal infection, once acquired, cannot be prevented from causing damage to the fetus. The administration of gamma globulin to the exposed mother does not seem to reduce the possibility of fetal viremia. By widely available serologic means we are able to identify those women who have acquired active infection in early pregnancy and whose infants are truly at risk. Therapeutic abortion of the pregnancies at risk is the only means by which the birth of severely damaged infants can be prevented.

The extent to which we can prevent the exposure of pregnant women to viral infections will depend, of course, on the extent to which these diseases can be prevented in the nonpregnant population. The results of field studies of a rubella vaccine now in progress are being eagerly awaited.

Exposure to Ionizing Radiation

The mutagenic effect of ionizing radiation was proved in fruit flies 40 years ago. Since that time, there has been little evidence that radiation accumulated during standard, diagnostic procedures has adverse effects on the human gonad. Upper limits of safety with respect to the dosage delivered to the human gonads or intrauterine fetus have been published, but safety is relative and the complete safety of any dose of radiation remains to be established. The teratogenic effect of therapeutic radiation delivered to the pelvis in early pregnancy, especially from the second to thirteenth week of gestation, has been amply documented. In the absence of specific knowledge, it would be wise to be ultraconservative with respect to exposure of the gonads and intrauterine fetus to radiation. A policy of avoiding pelvic radiation except during the first ten days following the onset of a normal last menstrual period should be urged. Every requisition slip should contain data regarding the last menstrual period and, whenever possible, fast film and image intensifiers should be used to reduce the amount of exposure.

While considering those opportunities for improving fetal health which are open to every physician, regardless of his field, the benefits to be derived from genetic counseling should not be overlooked. At the present time, the bulk of the responsibility is assumed by the obstetrician and pediatrician—usually after disaster has struck a family in the form of a child with a serious, hereditary disorder. Assuming that many prospective parents will opt for a reliable means of contraception when faced with a sure knowledge that each future pregnancy would carry a significant risk of producing a seriously incapacitated child, the possibility of preventing some birth defects exists. The premarital examination, for example, offers an excellent opportunity to probe for evidence of significant, hereditary disease. A meticulous family history, an accurate diagnosis of a suspect case and a reasonable working knowledge of the serious, hereditary diseases constitute the essentials for screening. It is obviously important that the risk figures communicated to a couple be as accurate as possible. When the physician does not wish to assume the responsibility of calculating the risk figures, help is available at most medical centers and from an increasing number of physicians having a special interest in medical genetics.

The theory that sensitization of Rh-negative mothers may be prevented by injection of Rh (D) antibody into the mother soon after the delivery of each Rh-positive infant has been confirmed and the antibody will soon be commercially available. With widespread application of this preventive measure, most, but not all, Rh isoimmunization problems of the future will be circumvented.

It may be argued that a constantly increasing surplus of population is the world's most urgent problem, that this country is not exempted from a responsibility to stabilize its population and that, until population growth is checked, large scale efforts to salvage our reproductive wastage are incompatible with our goal of optimum health for all. Ethical questions aside, this argument ignores the fact that there is no basic incompatibility per se between programs designed to improve the health qualities of our newborn and those designed to prevent a surplus of conceptions. Solutions for the problem of unrestricted population growth are desperately needed, but an upgrading of the population's health qualities is also indicated. If we agree with those who contend that a nation's most precious resource is its children, each of us has a responsibility to become the physician for the infant in utero.

The area of information about the neonate appears to grow as fast as the neonate himself. Pediatric literature is rarely devoid of an interesting and innovative study or concept in the field of neonatology.

RECENT CONCEPTS ABOUT THE NEWLY BORN

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Neonatal Thyrotoxicosis

The original description of neonatal thyrotoxicosis was made by White in 1912.[1] Since that original description, there have been approximately 35 cases noted in the literature. In each case the mother had current or had had previous thyrotoxicosis usually associated with exopthalmos.

The infants may present with a spectrum of signs and symptoms ranging from hepatosplenomegaly, congestive heart failure, marked supraventricular tachycardia, jaundice (with a tendency in some cases toward a direct hyperbilirubinemia) and thrombocytopenia. Additional reports have listed periorbital edema, thyroid enlargement, irritability, flushing, failure to gain weight and exopthalmos as signs which should be carefully observed.

It has been reported that congestive heart failure remains the most common presenting sign of thyrotoxicosis in the newborn. Of the 35 cases reviewed until 1965, there was a mortality of six newborns or approximately 17%. The remainder recovered and returned to a homeostatic condition within one to two months.

One of the initial questions to be raised was the possibility that maternal thyroid-stimulating hormone (TSH) crossed the placenta and was responsible for the neonatal symptoms. Hoffman et al state clearly that maternal thyrotropin is thought *not* to cross the placenta and state that only one case of neonatal hyperthyroidism has been described in the offspring of a hypothyroid mother.[2]

McKenzie found four out of five infants with neonatal thyrotoxicosis with significant levels of long-acting thyroid stimulator (LATS).[3] Long-acting thyroid stimulator is a 7S gamma globulin. It passes the human placental barrier and, therefore, the transitory character of the disease in infants reflects the maternal to infant passage and the natural rate of catabolism and subsequent ultimate disappearance of the exogenous protein.

In infants with neonatal thyrotoxicosis studied by Elas et al, long-acting thyroid stimulator was present in significant levels in the cord blood as well as the maternal serum.[4] There was six times the amount of LATS found in the hyperthyroid mother at delivery and two weeks post partum compared to the human serum control. The infant at birth was found to have long-acting thyroid

stimulator twice that of human serum controls. Sunshine et al determined that in one of their infants the LATS concentration fell exponentially with a half time of six days.[5] This is a biological half life which is much longer than that of TSH.

A thyroid gland was carefully studied on an infant who died from violent causes and who had suffered from neonatal thyrotoxicosis.[4] The infant was 13 weeks old at the time of death. The gland revealed hyperplasia with epithelial proliferation, colloid vacuolation and papillary infoldings. The same pathologic situation can be experimentally produced in the thyroid glands of mice given long-acting thyroid stimulator.

Several suggestions have been made for prevention and therapy. It is stated that hyperthyroid mothers who have pretibial myxedema and exopthalmos can be estimated to have high circulating levels of long-acting thyroid stimulator. Recommendations have been made to give the hyperthyroid mother sufficient propylthiouracil near term to suppress fetal thyroid over-activity. After birth and the recognition of neonatal thyrotoxicosis, the use of oral iodine such as Lugol's Solution has proven a satisfactory thyroid activity repressant. The question of possible exchange transfusion in order to remove much of circulating long-acting thyroid stimulator has been raised and deserves consideration when one is faced with the problem of severe neonatal thyrotoxicosis.

The Lesions of Congenital Rubella

The teratogenic effect of the rubella virus on the developing fetus has been recognized for many years and the recent epidemics of rubella have pointed up certain stigmata which were not usually thought to be of great importance.

The eye has long been known often to be severely affected by the rubella virus. The development of glaucoma or cataracts is well documented. Rubella virus has been isolated from the aqueous humor of infants with congenital rubella syndrome. However, recently the not infrequent occurrence of rubella retinitis has been reported.[6] The pigment disturbance most often involves the posterior pole of the eye and is most marked in the macular region. Morlet classifies three types of fundus changes: 1. A gross and generalized pigmentary change. 2. "Pepper-like" pigmentary changes occurring primarily in the peripheral areas. 3. Diffuse or peripheral moth-eaten areas in the retina without any pigmentary changes. The general feeling is that isolated rubella retinitis is benign, not progressive, and does not interfere with dark adaptation, peripheral vision or visual acuity.

Desmond et al demonstrated that 81% of neonates who had documented congenital rubella syndrome had signs referable to the central nervous system.[7] The manifestations of rubella encephalitis were described as having three possible courses. The first was an initially lethargic, hypotonic inactive infant with a large, full, anterior fontanelle who demonstrates poor weight gain, despite adequate intake, for the first four months of life with a tendency toward opisthotonus on handling and stimulation. About 50% of these infants may show a movement toward improving developmental progress between six and 12 months of age. The second type infant began as hypotonic and became hypertonic at about six months of age. Infections and feeding problems were frequent. If improvement were to occur, it would occur after the infant was nine months old. The third manner of presentation was an abrupt onset of convulsions or a meningitis-like picture—any time from the neonatal period to three months of age.

The neonate's spinal fluid demonstrates an increase in spinal fluid over 100 mgm% and moderate pleocyctosis. The protein level of the cerebrospinal fluid will diminish to normal after three months in the majority of cases. When the cerebrospinal fluid protein remains high, there is a higher percentage of mortality and neurological complications in that group. Positive virus isolation persisted in the cerebrospinal fluid for one year in 34% of the neonates and in one patient, virus isolation persisted for 18 months.

Of those 81% who were diagnosed as having congenital rubella syndrome with signs referable to the central nervous system, 20% died. Of those who survived, 32% demonstrated improvement at 18 months; 22% displayed only minimal improvement; 23% who had had severe initial symptoms were unimproved after 18 months. The neuromotor problems range from paresis and severe motor delay to hyperactivity, a hypoactive shoulder girdle and significant lateral foot rotation. In Desmond's study of 64 survivors out of the original 100 still in the study—44 out of 64 at 18 months still had one or more abnormal neurological findings. In support of those workers who are beginning to suggest that congenital rubella can be an active postnatal infection, it must

be pointed out that the protein level and cellular response in the cerebrospinal fluid increases after birth for a period of months in the severely involved infants.

Why do these infants have such poor somatic growth? One must note that a high percentage of them have intercurrent debilitating congenital abnormalities. However, also of distinct pertinence is the fact that cells infected by the rubella virus grow more slowly than uninfected control cells and have a limited doubling capacity. Careful cellular analysis has revealed an actual decreased number of cells in body organs studied in these neonates infected with the rubella virus.

The cardiovascular lesions are usually limited to the great vessels and the ductus. Thirty-four out of thirty-seven had such a cardiovascular lesion in a recent study with approximately 76% with a patent ductus arteriosus and 16% with coarctation of the aortic isthmus.[8] Another study revealed 55% with patent ductus arteriosus and 45% with pulmonic stenosis (33% valvular).[9] Korones suggested actual myocardial injury and necrosis can occur with the congenital rubella syndrome.[13] Hastreiter et al discussed the invariable presence of pulmonary arterial lesions of a specific type: a diffuse hypoplasia mainly affecting the proximal pulmonary arterial tree and extending into the periphery in a variable and asymmetric fashion.[8]

Renal lesions are not as commonly reported in congenital rubella. Gregg reported renal and ureteric manifestations.[10] Bullanti reported an abnormal kidney and double ureter [11] and Messner recently described an infant with congenital rubella syndrome with agenesis of the left kidney.[12]

The epiphysitis seen in the neonate with congenital rubella syndrome also deserves mention at this time.

Deafness, which is all too common, microcephaly, mental retardation, neonatal hepatosplenomegaly, petechiae, thrombocytopenia and hyperbilirubinemia are lesions also to be mentioned as being associated with neonatal congenital rubella syndrome although not currently discussed at length.

Magnesium Abnormalities in the Neonate

The metabolism of magnesium is becoming increasingly important in the consideration of abnormal neurological status in the newborn period.

Magnesium sulfate is still considered by many leading figures in the field of obstetrics as the drug of choice in controlling convulsions in the severely pre-eclamptic or eclamptic mother prior to delivery. The magnesium blocks neuromuscular transmission and decreases the amount of acetycholine liberated by the motor nerve impulse.

Chesley and Tepper compared maternal and cord blood magnesium after 10 gm magnesium sulfate was given to the mothers within one hour prior to delivery. The cord blood level of magnesium was 70–96% of that found in the maternal blood and required three hours to equal maximum levels. The amniotic fluid magnesium was averaged at 41% of the maternal serum level prior to delivery.[14]

The effects of magnesium on the adult in high doses are mimicked in the neonate. Hypotension begins at 3–5 meq./liter and lessened responsiveness and difficulty in micturition when the level exceeds 5 meq./liter. The deep tendon reflexes diminish at levels of 7 to 10 meq./liter and respiratory depression begins at approximately 10 meq./liter and above. Coma may ensue at levels of magnesium of 12–15 meq./liter with respiratory failure beginning at approximately 15 meq./liter and cardiac arrest at 24 meq./liter.

Studies with rabbits were undertaken by Aikawa and Bruno to investigate the maternal to fetal transfer of labeled Mg^{++} by maternal to fetal tissues. Their results show that Mg^{28} rapidly crossed the placenta and concentrated in the fetal tissues. As the fetal content increased, the placental content decreased.[15] This appears to be applicable to humans as well.

Brady and Williams described magnesium intoxication in a premature infant whose mother had received 11 gm of magnesium sulfate during the four hours prior to delivery. The infant was flaccid, apneic and cyanotic. The infant's first serum magnesium was at nine hours of age and was 15 meq./liter. This was unchanged at 16 hours and had fallen to 9.8 meq./liter at 24 hours at which time the infant continued to require respirator assist for maintenance of life. An exchange transfusion using blood with a normal Mg^{++} of 1.4 meq./liter resulted in significant lowering of the magnesium with spontaneous breathing and crying beginning during the procedure.[16]

Lipsitz and English presented 11 paired cases indicating the not unusual neuromuscular depression in infants whose mothers required large doses

of magnesium sulfate for eclamptic seizures. Certain cases required calcium gluconate intravenously as an antidote and assisted respirations for prolonged periods while others had temporary flaccidity and difficulty in establishing respirations. The duration of symptoms appeared to be directly related to the level of serum magnesium at birth and the maturity and efficacy of the renal excretory apparatus.[17]

The newborn can also present with the problems of hypomagnesemia. Davis, Harvey and Yu describe the cardinal feature of severe magnesium deficiency as seizures; other symptoms and signs are muscular weakness, vertigo, mental changes, gross tremor, and alterations in the electroencephalographic pattern. The authors showed by clearance studies that after a test dose of parahormone, a baby's own parathyroid gland was unable to respond to low blood levels of calcium and magnesium by reducing urinary loss of these elements. When plasma levels of Mg^{++} and Ca^{+} were depressed, the affected infant in their report was still excreting large quantities of magnesium and calcium in the urine.[18]

The mother of the affected infant in the Davis et al study had had a malabsorption defect with demonstrable jejunal mucosal abnormality and low normal serum magnesium levels. Dooling and Stern reported another case of combined neonatal hypocalcemia and hypomagnesemia with convulsions whose mother had a persistently low level of serum phosphorus. Evident from this latter case report was the inability of the infant to maintain the level of serum calcium despite supplementation until the serum magnesium was raised to normal levels.[19] Heaton and Fourmann suggested that magnesium deficiency interferes with the release of calcium from bone.[20] Gill et al presented evidence that the predominant effect of parathyroid extract is to increase the renal excretion of Mg^{++} possibly more as an increased release of magnesium from body tissues than a primary renal tubular effect.[21] Thus maternal hyperparathyroidism may be causative in neonatal hypomagnesemia. Bajpai also noted a reduced Mg^{++} after exchange transfusion due to the development of the Mg^{-} citrate complex when citrated blood is used in the procedure.[22]

What is normal for magnesium in the neonatal period? Using the ultramicromethod and utilizing Mann's dye which eliminates interference from calcium, Bajpai, Sugden et al found the mean value for 56 infants was 1.51 ± 0.12 meq./liter with venous blood slightly higher than capillary and breast- or bottle-fed infants not being statistically different.[23]

Thus we must add yet another perplexing chemical moiety—magnesium—to our already full armamentarium of biochemical abnormalities of the newborn.

The Infant of the Diabetic Mother

Body Water—Babies of diabetic mothers lost no more weight when compared with infants who were fed similarly and who had been born by the same route to normal women. This proved that excessive birth weight was not due to water retention.[24] Osler demonstrated that infants of diabetic women indeed have less extracellular water and less total water than is normal.[25]

Body Fat—Skin fold thickness and X-ray measurements revealed body fat to be increased by about 40% over the normal newborn.[26]

Hypoglycemia—Following delivery, glucose concentrations in the offspring of diabetic mothers declined rapidly to values below those observed in normals. Approximately 50% of these babies have glucose concentrations below 30 mg per 100 ml in the first six hours of life.[30] The rate of fall of blood sugar immediately after delivery was slowest in the normal infants, intermediate in the infants of mothers who have gestational pregnancy diabetes only and most rapid and significant in those of insulin-dependent diabetic mothers. The course of blood sugar levels can follow one of three courses. The majority have a transient, asymptomatic phase soon after birth lasting between one and four hours following which a spontaneous rise occurs. Some have a prolonged, sometimes severe, initial phase of hypoglycemia which may persist for several hours and may be associated with symptoms. The third course may, after an apparently benign initial phase, develop symptomatic hypoglycemia after 12–24 hours. When symptoms and hypoglycemia coexist, treatment is indicated: glucose intravenously with or without the simultaneous administration of glucagon. The use of fructose rather than glucose IV, predelivery to mothers and postpartum to neonate, has been advocated but remains a controversial issue yet unresolved. The use of steroids and diazoxide are also to be mentioned as valuable in the refractory hypoglycemic.

Acid Base Balance—Lowrey, Graham and Tsao discovered that infants of diabetic women who were distressed when compared with the normal newborn tended towards an uncompensated acidosis with lowered plasma pH and raised PCO_2 values as well as reduction in the total base.[27] More recently Prod'Hom et al found that the acid-base balance at one and four hours in cord and arterial blood of well, undistressed babies differed little from the norm.[28]

Hypocalcemia—A temporary, symptomatic state of hypocalcemia as a common feature of the infant of the diabetic mother has been repeatedly reported and seen by physicians dealing daily with the neonate. The etiology is poorly known but may result from a transient state of hypoparathyroidism.

Hyperbilirubinemia—There is a distinct tendency to elevated bilirumin levels at 48 hours of age in these infants unrelated to increased hemolysis or hemolytic disease. Taylor suggests that the cause rests in glucuronyl transferase inadequacy combined with hypoglycemia.[29]

The tendency for the infant of the diabetic mother to develop the respiratory distress syndrome is probably more related to the planned prematurity of the birth and the often Caesarian section modality of delivery rather than a direct effect of the diabetic status of the mother itself.

A list of references will be supplied upon request.



CARE OF THE NEONATE AND INFANT



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In his State of the Union address to Congress in 1968, President Johnson, informed the Congress of a fact that all physicians have known for many years, *i.e.*, the United States ranks 15th in neonatal and infant mortality among the other nations of the world.

The infant is at greatest risk during the first week of life, then the first month of life, and finally the next eleven months. Seventy-two percent of infant deaths under one year of age occur during the first month of life. The overall infant mortality rate is 23.4 deaths per 1000 infants.[1] The importance of the neonatal-infancy period cannot be too strongly stressed. The foundation of feeding practices, child-parent relationships, preventive medicine in the form of accident prevention and immunizations, rapid growth and development, and various disease states all take their beginning at this age.

There has been very little decline in infant mortality during our time. The prospect of having reached an irreducible minimum pacifies many doctors and irritates others. The drop which has leveled off in the last years can be related to the following factors: [2]

1. Sterilization of milk
2. Increase in socio-economic status
3. Mass education
4. Preventive medicine
5. Research and application

Of the five factors mentioned, sterilization of milk probably has done more to lower infant mortality than the other four combined. The private practitioner exerts his influence on infant mortality through the latter three factors: educating the patients, utilizing preventive medicine, and the application of medical research. The delivery of medical care, in an ever increasing doctor-patient ratio, must be organized into some routine format that incorporates these factors. A routine and modus operandi for which I have found great satisfaction is the following:

Scheduled Visits

1. Age 1 to 6 months—monthly check-ups
2. Age 6 months to 2 years—check-ups every 3 months

Physician Responsibilities During Visit [3]

1. General physical examination and evaluation of growth and development
2. Feeding instructions
3. Performance of preventive medicine
   (a) Accident prevention
   (b) Immunization
4. Performance of special tests
   (a) PKU
   (b) Hemoglobin
   (c) Urinalysis—urine culture
   (d) Tuberculin skin tests

The visit schedule is self-evident but some comments regarding the divisions of the physicians' responsibilities need to be made.

Physical Examination and Evaluation of Growth and Development

In the care of children it is very necessary that the physician's examining facilities be geared to the child's exam handicaps. The examination room should be very brightly lighted in order to bring out and scrutinize the various skin rashes and conditions occurring from birth to the second year. The room should be free of any extraneous noise so that examination of the heart and lungs, which, by virtue of the child's temperament, may be difficult otherwise, but especially difficult where there is construction or loud street noises as a background to the physician's room. The room or another room should be able to be completely blacked out for transillumination examination, which is useful for intracranial, scrotal and even intra-abdominal diagnosis.

The child should be completely undressed during the examination; a ludicrous statement, but lesions may be missed due to a hurried, clothed exam or an exam done out of respect for false propriety.

Measurements of the weight and length are done at each examination and plotted on an appropriate growth grid chart.

Circumferential measurement of the head should be performed and plotted on a growth grid chart for the first six months. These measures are necessary because the child's weight from birth to the first year will usually triple and his height will increase by one and one-half times. It will take seven more years for the child to grow this much again. The skull and its valuable contents, enlarges approximately one-third of its birth size and again will not do that for another five years. This rapid growth is important to document and important in order to diagnosis its earliest detours toward abnormality. A complete physical exam should be carried out and a developmental discussion should take place between the parent and physician either during the examination or afterward. This should include such things as: Does the child follow objects with his eyes; does he recognize persons; does he smile; can he roll over; can he sit up; can he stand; can he transfer objects from hand to hand; does he use his thumb and forefinger; etc. (The reader is referred to the Standards of Child Health Care by the American Academy of Pediatrics [3] for a thorough outline of this subject.)

Feeding Instructions

Probably in no other area of the newborn's care does the "art" of medicine take more of a stand than in the feeding of infants and children. This is the great wasteland of the medical art wherein there is extreme divergence of both lay and professional opinion. In no other place of medical care are so many third experts prone to stick their fingers and play doctor. The "Gerber" Baby has become the paragon of babies, attesting to the great influence of Madison Avenue. In a society so affluent as ours it has made colic as American as the hot dog or home run.

Milk: Let me begin by asking the question—"Are you a bottle man or a breast man"? I, personally, am a breast man. To me there is no better way for a baby to be fed and no better way for a baby and mother to get to know one another. Certainly, I am in the minority today but there seems to be a rebirth of this method of feeding.

Commercial formulas and milks certainly give the baby everything that is required for growth and development and properly so. At any particular time in infancy, I challenge anyone to single out the breast- or bottle-fed infants from any group of infants. The meticulous calculations of the older physicians is no longer necessary and we modernists simply have to mix water to certain parts of prepared milk formula. Milk is the "staff of life" for the child until he is six months old. However, certain physiologic infant handicaps must be kept in mind when using artificial milk. Breast milk innately meets these requirements. A low solute load is a mandatory item. Newborn kidneys are functioning at approximately 50% of mature kidney function. Kidney maturation occurs by six months of age. Until then the newborn is unable to concentrate his urine well and therefore a high protein-solute load will cause azotemia and an obligatory renal water loss, which is harmful at such stressful times as diarrhea, vomiting, or fever. Whole milk can be started by the age of five to six months.

Improper mixing instructions or leaving too much interpretation up to the inexperienced parents continues to cause iatrogenic illness. Sterility of the milk is still necessary despite our modern conveniences, but the ritualistic behavior of our grandparents, and even our parents, can be done away with by industry's sterile prepackaging of today.

Babies born of allergic ancestry, should be sheltered from early exposure to known allergic substances, of which cow's milk protein is but one. Commercial formulas which are non-allergenic can be substituted for these children, and should be used for one year.[4]

Vitamins: People in the United States spend approximately $350,000,000 a year for the use of vitamins. The use of any vitamin is probably uncalled for with the exception of vitamin K in the perinatal period and added amounts of vitamin C and D in the first six months.[5] The indiscriminate use of vitamins as a supplement to the child's diet, above and beyond the recommended daily allowances, is to be condemned and the failure to recognize that adulteration of various infant foods with vitamins occurs and appreciably adds to the daily vitamin intake, is negligence. In the first year of life the child needs the following vitamin requirements:

Vitamin	Requirement/d
A	1500 U
B	"micro mini" amounts
C	30 mg until 3 months and 60 mg over 3 mos.
D	400 U
K	1 mg perinatally only

Breast-fed infants and infants not taking the entire contents of the pre-packaged milks do not receive enough vitamin D and C in their diet so that added vitamins must be prescribed. The current concentration of vitamins in infant preparations gives more than enough in the 0.6 cc volume. The following are general descriptions of the formula and vitamin concentrations of vitamins:

Formulas/can	Commercial Vitamins/0.6 cc
A—1500 U	A—3,000 U
C—50 mg	C—60 mg
D—400 U	D—400 U

At these concentrations the only vitamin that needs to be worried about, because of excess, is vitamin D. The vitamin D scare of intoxication has received great public notoriety and perhaps over exaggeration. Effects may occur at levels of 1800 U/d with growth retardation, anorexia, and poor retention of calcium and phosphorus but the usual toxic dose is in the neighborhood of 1,000 to 2,000 U/kg/d and enormous doses were used in those cases so notoriously published. However, in a study performed on children's diets, Dale[6] showed that 10% of the children were re-

ceiving 1,000 to 1500 U a day, 9% 800 to 1,000 U/d, 50% 400 to 800 U/d, and 31% less than 400 U. Therefore, the practitioner should not shy away from the use of vitamin D in an infant where the requirement in the first six months of life lies somewhere between 400 to 800 U/d. All breast-fed babies require supplementation and bottle-fed babies if their D intake is in the low range.

Fluoride: The use of fluoride in combating tooth decay is a child of our generation.[7] Again, controversy and organizations fighting its use are still prevalent, but in our area fluoridation is the practice and the rule. However, very little thought is ever given to its use during the first two years of life when it will do the most good. Our water supply contains on the average of 0.8 mg/l. The recommended daily fluoride intake is 1.0 mg/d. The toxic amount of fluoride to avoid is 4.0 mg/d, so that our margin of error is quite great. Breast milk contains approximately 5 to 10% of ingested fluoride—therefore it is low in supply; commercial formulas contain no fluoride. Only when reconstituted with our water supply, in a 13 oz to 13 oz volume, do they contain about 0.4 mg/volume of formula. Each child should have a supplement of fluoride added to his diet in order to keep the concentration in the 1.0 mg/d level. This is accomplished by adding 0.5 mg/d to any of various commercial preparations.[8]

Solid Food: Before 1920, solid foods were infrequently started in children before they were one year of age. Growth, development, and prevention of anemia were enhanced by the earlier administration of solids so that in 1930 Marriott advocated the use of solids at the age of six months. In 1937, the Council on Nutrition of the AMA advocated the use of solids at four months of age. In 1943, Brenneman is quoted as saying, "While there is still great divergence of opinion as to what—when—and how much to feed babies, one thing is clear, there has been a steady tendency to give more and to give it earlier." This applies as much today as it did 25 years ago.

In 1954 a quarterly review of 2,000 pediatricians took place in regard to their feeding practices. The result of this review showed that 86% were starting solid foods by three months of age and 66% by six weeks of age. In 1967 the American Academy of Pediatrics in their Standards of Child Care, published a feeding schedule in which solid foods are begun at two months of age.

The subject of when and what solid foods to



start has certainly been a "hawk *vs.* dove" topic for many years. The hawks claim that too early institution of solids produces colic, constipation, vomiting and allergy.[9] The doves claim that starting solids early, alleviates hunger, produces earlier sleep patterns, makes the child's schedule more regular, and improves growth and development.[10] Approval or disapproval of both camp's claims can be found in the general medical literature.

A helpful and practical study for feeding solids to infants was done by Beale.[11] She studied when and what solids infants will best accept. Beale showed that CEREAL, especially Rice, is well accepted at the age of two to three months; FRUIT, especially applesauce and bananas, by two and one-half to three months; VEGETABLES, especially yellow vegetables, by four to four and one-half months; MEATS by five and one-half to six months. The hated solids were beets, spinach, and liver. Table foods may be started by six months of age.

Preventive Medicine

Accident prevention: This is the pediatrician's patient-education responsibility. Needed are informative instructions, warnings, age-oriented descriptive pamphlets of accident pitfalls, and a common-sense approach as to what the parents should expect as the child grows up.

The first year is relatively accident free, but in the second year the infant takes on more and more added risks until it out-does all other forms responsible for hospitalization and mortality.

Immunization: Routines for immunization are well outlined in various textbooks and subjects on the matter.[12] Today, pediatricians follow the

recommendations of the Committee on Infectious Disease of the American Academy of Pediatrics and their routine for the child's first two years, is as follows:

Age	Immunization
2 months	DPT and Trivalent oral polio
3 months	DPT and Trivalent oral polio
4 months	DPT and Trivalent oral polio
12 months	Live measles vaccine
15 months	Trivalent oral polio vaccine booster
18 months	DPT booster
21 months	Smallpox vaccine

Some general rules regarding the use of the various immunizing agents must be kept in mind. Acceptable contraindications to their use are:

1. **Any acute illness**
2. **Cerebral damage—delay until the child is over 1 year**
3. **Dermatitis, especially eczema—defer smallpox**
4. **Any child on immunodepressive treatment**
5. **Simultaneous use of live vaccines**
6. **Children over age 8 should discontinue the use of vaccines containing pertussis and use only adult DT**
7. **Site—upper outer thigh, deltoid and the buttocks may also be revisited**

The reinstitution of the use of the buttocks as an immunizational site is worth mentioning. The buttocks use was discontinued because of sciatic nerve palsy, and physicians were cautioned to use the lateral thigh. Recently, complications of this site have been seen with fibrosis of the quadriceps group and withered legs. Therefore, proper parenteral injection technique must be adhered to—site of injection does not excuse proper technique. The "buttocks revisited" with a proper injection is still good medical practice.

Dos and Don'ts Regarding the Use of Various Immunizations

DPT

☐ **Missed Shots**

Many physicians are concerned over what to do for the infant who has had disruption in the shot schedule routine. If no more than 12 months has elapsed between shots, the child can be placed on his routine schedule because the shots may be given 1 to 12 months apart with equally good effect. If more than 12 months have elapsed between shots then the child should receive the total amount of antigen, at monthly spaced shots, which he would have received had they been given by the usual schedule. This generalization of total antibody response being proportional to the total antigen innoculated will bring the child up to date.[13]

☐ **Boosters**

DPT boosters are given at age 3 and 6 and then pertussis is dropped from the vaccine and adult DT is given every 5 years thereafter.

☐ **Wounds**

Tetanus toxoid for injuries should be used as follows:

Any clean wound within 12 months of a tetanus toxoid requires no tetanus toxoid booster.

Any dirty wound regardless of when the last tetanus toxoid was given should receive a tetanus toxoid booster within 24 hrs. of injury. No antitoxin is necessary if the child has received tetanus toxoid within 12 yrs. of injury. A toxoid booster will bring this child's protection up to adequate levels over that time range.[14, 15]

SMALLPOX

☐ **Brain Damage**

Do not give the vaccine to children under 1 year of age. An increased incidence of encephalomyelitis occurs under 1 year of age.

☐ **Booster**

Booster smallpox vaccines are done every 5 years.

☐ **Site**

The site of the vaccination should always be in the deltoid area despite mothers' pleading for cosmetic reasons.

☐ **Eczema**

Don't give the vaccine to any child with eczema or do not vaccinate any normal child whose siblings have eczema.

☐ **VIG**

Vaccinia immune globulin is available for use in complications of smallpox vaccinations and in special cases where vaccinations must be done to persons in the contraindicated groups.

POLIO

☐ **Vaccine Type**

Always use the Sabin vaccine. Trivalent Oral Polio preferred.

☐ **Boosters**

Booster doses of Sabin vaccine in the form of a Trivalent Oral Polio, should be given every 3 to 4 years to the high risk groups such as children, medical personnel, and during pregnancy.

MEASLES

☐ **Vaccine Type**

Always use the live measles vaccine. The killed vaccine should be abandoned because of local reactions received by these children when given the live vaccine and, more importantly, when these children are confronted with natural measles they develop an atypical systemic illness which may be lethal.

☐ **TB Skin Test**
Always do a tuberculin skin test at least 6 weeks before the measles vaccine is to be given. Live measles vaccine may prevent a positive skin reactor from reacting.

☐ **Contraindications**
Do not give live measles vaccine during pregnancy, leukemia, immunodepressive treatment, any febrile illness, with other live vaccines, to any person allergic to egg or dog dander, or to anyone who has received gamma globulin within 6 weeks.

☐ **Positive TB Reactor**
Any positive tuberculin child should receive INH for 6 weeks if he is given the live measles vaccine.[16]

MUMPS

☐ **Restricted Use**
For now, mumps vaccine should be limited to males over 10 years with no history of natural mumps infection. Until more long term data becomes available, young children should be allowed to contract natural mumps in order to possibly avoid the creation of a huge susceptible postpubertal herd.

☐ **Exposed Persons**
Mumps vaccine requires 6 weeks to produce protection, thus failing in exposed persons because of mumps shorter incubation period. Much used inactivated mumps vaccine or hyperimmune mumps globulin has no protective effect in exposed persons and should be abandoned.

Special Tests

PKU test: A blood PKU test should be performed on all neonates while in the hospital and a urinary PKU test at the first monthly check-up with the simple Phenistix test. The simplicity of this examination and the value of its performance are well known. The small incidence of this defect does not mitigate against the use of the test. Increase levels of phenylalanine in the blood should be investigated for other causes than the primary defect.

Hemoglobin: The hemoglobin should be performed somewhere between the sixth to the 12th month. At that time, the maternal supply of iron has been completely dissipated and the prevention of anemia with iron supplements can only be done by assaying the blood hemoglobin. The normal hemoglobin drop at the third to the sixth months of around 10 gm has taken place and if the hemoglobin is below 10 gm the child should be placed on prophylactic iron medication. Other hemoglobins should be performed at approximately six month intervals until the child is two years old.

Urinalysis—Urine Culture: A clean urine specimen should be obtained on all children at least once a year and at any time wherein suspected urinary pathology manifests itself. Evaluation of the urinary sediment and gram stain of the sediment is important for diagnosing bacteriuria and a convenient screening test for urinary infection, Testuria, is very applicable to small infants since it requires only the wetting of a dip stick for the test. The value of diagnosing asymptomatic urinary tract infection in infants is one of the most gratifying services a physician can perform.

Tuberculin Skin Test: This test should be applied when the child is nine months old. This is done three months before the live measles vaccine is administered. A Tuberculin skin test should be done at yearly intervals thereafter or until it becomes positive. The Tine test is a simple and easily administered test with excellent reproducible results and compares very favorably with the intermediate strength PPD.[17]

Positive tuberculin skin reactors may be found at any age. The question of what to do with positive tuberculin skin reactors is often brought up and can be summarized as follows:[18]

Positive TB Skin Test	Treatment
(1) Child under 4 years	**INH X 12 months**
(2) Recent convertor over 4 yrs.	**INH X 12 months**
(3) On steroid treatment	**INH during steroid treatment**
(4) Rubeola or Pertussis	**INH X 6 weeks**
(5) Receiving Measles vaccine	**INH X 6 weeks**

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It has been traditional throughout the years that those of us who have the responsibility for the health care of our nation's children have taken enthusiastic leadership in Preventive Medicine. The General Practitioners, Pediatricians, and Public Health Physicians have worked harmoniously together toward the goal of the eradication of childhood diseases through prevention. The progress toward this goal has come about through the development of new vaccines, through Public Health measures in sanitation, and through the education of parents along lines of improving health standards. Parents are becoming increasingly more aware of the value of immunization procedures, regular physical examinations, etc. which are included in high quality standards of child health care. In the future the former indigent patients will demand and will receive the same high quality care and the physicians delivering that care will be adequately compensated.

PREVENTIVE PEDIATRICS— A NEW LOOK

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The studies in preventive medicine since the turn of the century have been remarkable. It has been said that more progress in medicine has been made in the past 25 years than in the entire history of medicine. It has also been estimated that our medical knowledge has doubled in the past eight years.

We have seen the eradication of such contagious diseases as smallpox, poliomyelitis, measles, diphtheria, typhoid fever, and now mumps with the new vaccine. The rubella vaccine is just around the corner and an intensive "crash program" is under way to produce an effective all-purpose respiratory disease vaccine. There has been a reduction of tetanus throughout most of the world, and the anti-rabies preventive therapy has been greatly improved and is used with less risk.

The reduction of infant mortality from diarrheal disease has been another dramatic chapter of our century. This has come about with the improvement in infant feeding, improved sanitation, and health education of parents. In the early years of this century there was the parental dread of the second summer of the baby's life. During the first summer, the infant was usually still breast fed, but the second summer brought on diarrheal disease and the mortality rate was very high. Progress in prevention of diarrheal disease began with the percentage formulas which had to be calculated with mathematical accuracy. The specialty of pediatrics partly got its start through this new and complicated knowledge of formula preparation which contributed so much to the eradication of diarrheal disease. Witness the progress in the simplification of formula preparation up to the packaged ready-to-use formulas today.

Prevention of nutritional diseases and vitamin deficiencies has also made remarkable strides in this century. Scurvy and rickets were very prevalent while I was in medical school and were seen regularly in the outpatient departments of all hospitals. Many physicians finish their training program now without ever having seen a case. Protein deficiencies have been greatly reduced in our coun-

try, but still constitute a major problem in many other countries. Research continues to try to find a palatable and inexpensive protein dietary additive. Several such products are already available and just this month the FDA has finally given approval to the fish protein concentrate in the form of a flour which is made from the whole fish. This product has been pushed by the Agency for International Development and may find more acceptance in other countries than here. In certain areas of our country, however, many children are still on protein deficient diets due to ignorance, poor food habits, or economic factors. This is now receiving a great deal of attention in Congress and a thorough study of the nutrition of the entire population will soon be launched. A study of this kind will do much to clarify the controversy along these lines.

Another recent and extremely important milestone in preventive medicine was the discovery of a special blood fraction called 7S gamma globulin. The Division of Biologic Standards of the National Institutes of Health has licensed this new vaccine known as RHO-GAM, which, as you know, will be given to RH-negative mothers to prevent babies having Erythroblastosis Foetalis. It is estimated that this new vaccine will save the lives of 10,000 newborn infants each year in the United States. Thus we have another addition to our expanding knowledge of the prevention of RH incompatibilities.

This enlightened and exciting era of medicine in which we live gives even more promise of new discoveries. It was startling to read some few years ago Aldous Huxley's *Brave New World* in which he predicted test-tube babies, control of chromosomes and the possibility of man's manipulation of the human race in the future. With the expanding knowledge of chromosomes and the recent production of a living cell from chemicals, Huxley was a prophet ahead of his time. We consider as commonplace today such things as organ transplants, intrauterine transfusions, new enzyme chemistry developments, a continuing breakthrough on chromosome abnormalities and an ever increasing list of inborn errors of metabolism. A recent abstract on "Inborn Errors of Amino Acid Metabolism" listed 34 types, many admitted to be extremely rare. Early detection is most important, for therapy may prevent or lessen possible neurological damage. These discoveries will lead the way to the prevention of many heretofore undiagnosed cases of mental retardation.

The New Look

Environmental hazards constitute a variety of extremely important problems with which we have to cope daily. Today in pediatrics, accidents constitute by far the most serious environmental hazard. In spite of the concerted efforts of accident prevention committees of all our medical organizations, industry, lay groups and governmental agencies, the mortality rate from accidents in children far surpasses all other causes. We still need further automobile safety measures and a continuing effort toward driver education. As for accidental poisoning, we need expanded and improved poison control centers and again constant parental education along these lines. Much of this type of education can come through our private offices, in schools, PTA groups, etc.

Other environmental hazards with which all physicians should be involved in prevention include air and water pollution, rat control, slum clearance, and the increased threat of irradiation dangers. Prevention of these hazards will have to come through local, state, and national legislation and it behooves all of us to become personally involved as far as possible at the local and state levels in the promotion of adequate legislation toward this goal.

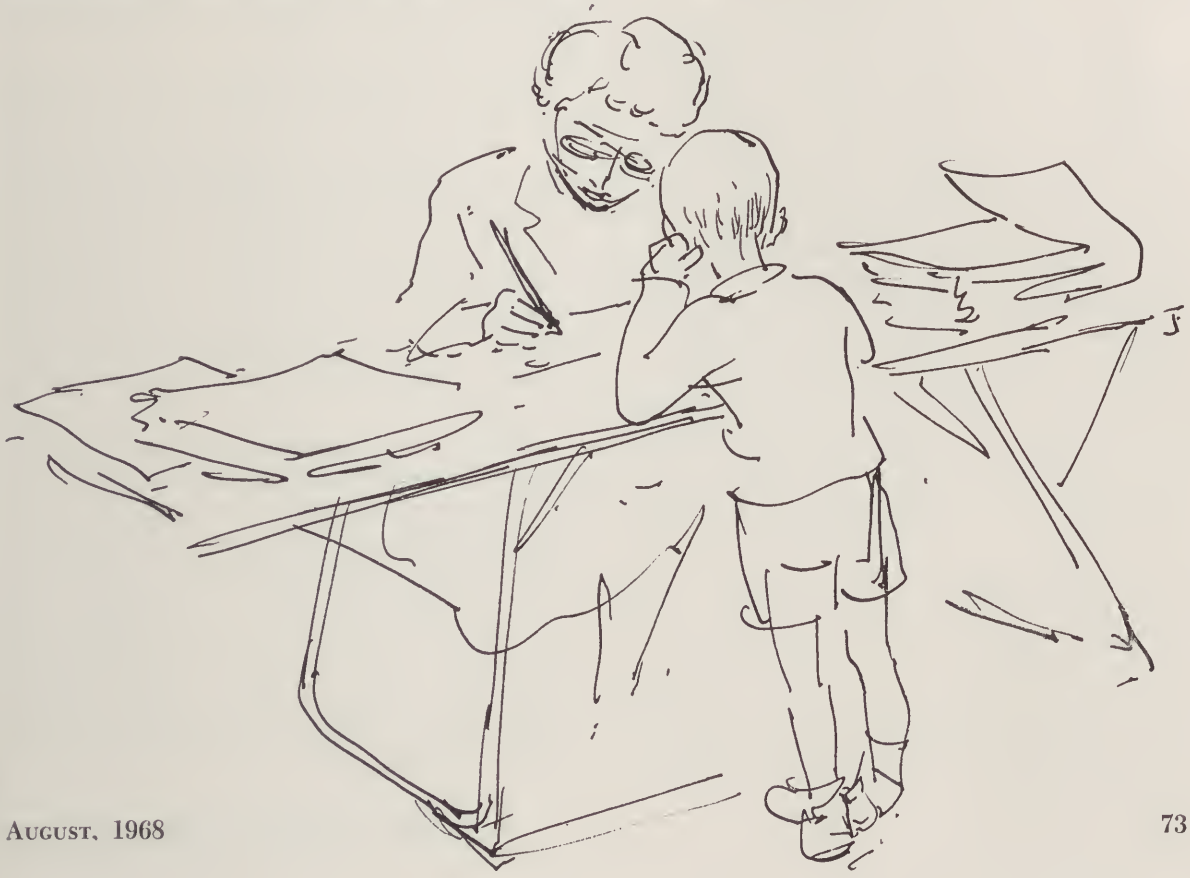
Prevention of birth defects is a new chapter in Preventive Pediatrics which will be an extremely important one in the years to come. We are just on the threshold of new knowledge and much investigation is now under way to test the mutagenic properties of many chemicals that we ingest or breathe. It has been proven that a number of chemicals are known to cause genetic damage in bacteria and other organisms. LSD has been shown to cause chromosome breaks in the laboratory, and clinical evidence is now building up to the same conclusion. Chromosome-effect studies are being launched on a world-wide basis and attempts will be made to estimate whether or not birth defects are on the increase. It seems imperative to try to establish a birth defects register which will require all our cooperation. At the same time it is even more important to establish an up-to-date register of potential mutagenic drugs.

Another area of deep concern to our entire medical profession is the infant mortality rate in the United States. Emphasis on prevention here is paramount. In spite of the fact that there may be some differences in reporting mortality rates in the different countries, the fact still remains that

the United States ranks 15th among other nations of the world. In spite of the fact that the infant mortality rate has dropped in the past four years, 22 babies out of every 1,000 live births die in our country. Plans to combat this serious situation include better education, improved nutrition and especially the establishment of neighborhood health centers where prenatal care will be readily available. Apparently 20 such centers are in operation and funds are available for 41 more. However, a recent HEW survey shows that 600 such clinics are needed. Other factors in the prevention of this situation include slum clearance, health education, improved nutrition and the prevention of unmarried teen-age pregnancies. Poverty control programs will help to reduce this infant mortality rate and much further legislation will be needed to implement these plans.

Another category of conditions where prevention will be studied in depth is the perceptual handicaps such as primary reading disabilities, dyslexia, etc. These conditions seem to be seen more now in practice, but perhaps it is because we are more aware of the condition than formerly. We see with increasing frequency the hyperactive child, sometimes destructive, with short attention span, easy distractability, and spotty and irregular achievement performance. These children are exasperating to their parents in the pre-school age and present major difficulties once in school. Fine motor coordination is frequently lacking and this can affect handwriting. Teachers are trained to spot these children early and a diagnostic survey which includes hearing, visual, psychometric testing and a complete physical and neurological examination is imperative. By early detection of these children, much heartache can be prevented and much time and effort and money saved in the careful planning of the educational course for the future. A study is still under way at the National Institutes of Mental Health on Minimal Brain Dysfunction which covers most of these conditions. The term Minimal Brain Dysfunction rather than Minimal Brain Damage is a much more comfortable term for the parents to accept, particularly since it is difficult if not impossible to prove the damage. The cooperation of the teachers in the early detection of these cases is helpful except when the teacher oversteps her authority and tells the parents that their child has Minimal Brain Damage before consulting a physician. Perceptual Handicaps may even be a better term than Minimal Brain Dysfunction.

Perhaps the most important chapter on Preventive Medicine which remains to be written concerns the problems growing out of the social unrest of our times. The youth of today is in a state of turmoil and rebellion. There is an alarming



increase in lack of discipline, respect, honesty, etc. Instead there is racism, bigotry, prejudice, disrespect for the law and the property of others, dishonesty and a loss of basic moral values. Youthful shoplifting has become a national epidemic and has almost become an accepted way of life. According to the FBI, shoplifting arrests have increased 79% in the past five years, and 50% of those apprehended are under 21 years of age. It is an admitted fact that these youngsters rarely steal out of economic need. The National crime rate is up 62% since 1960 with only a 9% population increase, and the 15-year-olds lead the list of those arrested. Vandalism is also up 50% in certain areas. It is particularly high in Montgomery County. It is by no means confined to the poorer economic strata. School drop-outs, drug addiction, delinquency, illegitimacy, and personality disorders continue to increase rapidly.

Runaways from home are increasing every year and constitute one of the major problems of the moment. Recent statistics have revealed that girls now equal boys in running away from home. Washington, D.C., had at least 4500 juveniles officially missing at one time last year, about 10% of whom were under 11 years of age. Montgomery, Prince George's and Fairfax Counties each had more than 1000 runaways in 1967.

Where The Blame Lies

When faced with these types of problems it is logical to ask how and where have we failed as parents and as physicians? The weakening of the family unit with a continuing loss of moral values and sometimes a complete lack of communication has contributed greatly to these troubles. In certain cases, however, our society is at fault even more than the parents who are being continually blamed. All of us have witnessed school drop-outs and runaways in families we considered stable, intelligent and close-knit. Our materialistic way of life and our permissiveness and overindulgence have also been factors. Most psychiatrists believe that the youth of today are much more secure and happy if they are given boundaries of activity with mutual understanding and planning.

How can we then as parents and physicians work together toward the prevention of some of these problems? Honesty, cleanliness, respect for the law and property of others, good manners are all attributes of parental example. We should work toward the strengthening of the family unit with a return of a family sense of moral values. We should be sure that the lines of communication in our families are kept open. Many physicians give teen-agers their private telephone numbers, encouraging a call day or night in case the line of communication between the youth and parents has broken down in the home. It behooves us also to try to be more sympathetic and to also try to understand the philosophy of the youth in rebellion.

In order to try to prevent some of these problems for the future generations, the physician should be on the alert to detect behavioral aberrations and breakdowns in familial communication. The general practitioner is in a better position than either the internist or the pediatrician in the continual observance of the family unit. The pediatrician rarely has the opportunity of getting to know the father in the family. During the period from birth throughout adolescence, the general practitioner and pediatrician have a particularly unique opportunity to observe the family in his day to day practice. We can exert much more influence in the future along preventive lines than we have in the past in family counseling. We have given far too much of our time and energies to physical health and not nearly enough to mental health. The Joint Commission on Mental Health of Children has seven task forces of representative experts in child mental health. Prevention along lines of mental health will be one of the keynotes of the final report which will be available some time next year.

All of us in practice today, in order to extend our effectiveness, will have to "re-tread" ourselves in our office practices. We will have to learn the use of allied health personnel with nurses, social workers and other physicians' assistants. We shall all eventually have many of our routine details handled by computers which will leave more time for the personal things which will strengthen rather than weaken the one-to-one physician-patient relationship which we must never lose.

The ever increasing and ominous reports of the social unrest and youth in rebellion in this country and throughout the entire world present a disturbing picture of the present and portends a rather disheartening future. Never before in the history of medicine has there been such a challenge along preventive lines. This burden falls squarely on the general practitioner and the pediatrician alike. Our responsibility is great and the message is clear. We must all take a *New Look* at Preventive Pediatrics.

ACUTE INFECTIONS OF THE RESPIRATORY TRACT OF CHILDREN

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Acute respiratory tract infection, from the common cold to bronchopneumonia, is the most common disorder for which a physician is consulted. In a Cleveland Study [1] of 25,000 illnesses in Cleveland families during a ten-year period, Drs. Dingle, Badger and Jordan found that 63% of all illnesses were respiratory tract diseases. Ninety-five percent of these were classified as common respiratory disease, which included the common cold, rhinitis, laryngitis, bronchitis and other undifferentiated respiratory disease; 2.8% were streptococcal tonsillitis and pharyngitis; 1.4% were non-bacterial tonsillitis and pharyngitis and the remainder were pneumonia and influenza. Individuals in the study had an average of 5.6 common respiratory disease episodes annually. The highest incidence occurred during the second year of life when children experienced an average of 8.3 infections yearly; this made up 70% of their total illnesses. This rate remained high during the pre-school years; during the fifth year, each child averaged 7.4 cases per year. Thereafter, with increasing age, there was a slow and steady decrease in the yearly number of respiratory infections.

Etiology

For the practitioner, the basic problem in respiratory tract illness concerns the etiology of each infection because the etiology determines whether one should treat with an antibiotic or not. Many different bacteria, mycoplasmas and viruses can cause respiratory tract infection; since the respiratory tract tissues can respond to these different stimuli in a limited number of ways, pathological changes evident on physical examination are usually similar regardless of etiology. There is no single physical sign which assures the examining physician that a specific infection is either bacterial or viral. Nevertheless, certain clues can be helpful in making an etiologic diagnosis:

- ☐ Knowledge of what is being passed around the community at any given time
- ☐ Knowledge of population and age specific susceptibility
- ☐ Eliciting the history of exposure to a recently ill person whose symptomatology and clinical course can be obtained
- ☐ Knowledge of subtle differences which varying agents may cause in the history or physical examination.

The usual bacterial agents which cause acute respiratory tract infection are D. pneumoniae, Beta hemolytic streptococcus, Staphylococcus aureus and H. influenzae. Bacterial cultures are readily available in all clinical laboratories and are becoming more available in doctors' offices and county health departments.

Over the last 10 or 15 years, viral studies have increased our knowledge of the viral etiology of respiratory tract illnesses remarkably, but viral studies are not usually available or practical in the clinical laboratory. If they were readily available, the presently used techniques would not help the clinician at the time when treatment should be instituted. Therefore, the value of extensive studies, such as those at Children's Hospital of D.C., can be shown in providing a statistical basis for clinical diagnosis. Through correlation of the clinical picture with that of virus isolation and serological tests, these studies have provided good data on the relative contribution of different agents to illness. Table I [2] shows the etiology of total respiratory tract illness in 8,000 children requiring hospitalization over a ten year period.

Other viruses which are capable of causing respiratory tract illness in children, but are not as common or do not tend to produce illness requiring hospitalization are the picornaviruses, particularly certain rhinoviruses and certain Coxsackie viruses.[3]

TABLE I

CONTRIBUTION OF NON-BACTERIAL AGENTS TO RESPIRATORY TRACT ILLNESS REQUIRING HOSPITALIZATION

Adenovirus	**7%**
Influenza	**4%**
Para-influenza	
Type 1	**5%**
Type 2	**2%**
Type 3	**12%**
Respiratory Syncytial	**28%**
Mycoplasma Pneumonia	**10%**
No detected virus as etiology	**32%**

Upper Respiratory Tract Infections

Acute upper respiratory tract infections include the common cold, acute rhinitis, acute nasopharyngitis and acute pharyngitis and can be grouped for simplicity under the term "upper respiratory tract infections." However, the infecting agents are not always so accommodating and may infect other areas of the respiratory tract as well.

The presenting signs and symptoms are usually more severe in infants and younger children than in older children and adults. In the young child, fever is a prominent symptom accompanied by irritability, restlessness, nasal obstruction, sneezing and cough. The older child will have sneezing, coughing, chilly sensation, muscle aches, and headache. Physical examination will reveal nasal congestion with a watery discharge, red eyes and pharyngeal inflammation. The exam should be thorough to rule out the complications of otitis media, especially in the young child, and sinusitis, meningitis or pneumonia.

The problem confronting the practitioner concerns the decision to use antibiotics or not. We all use antibiotics too frequently under the rationale that we are preventing the invasion of bacteria into an already injured area. This is not acceptable reasoning both because it is not proven to be helpful in controlled studies and because we have seen the emergence of bacterial resistance to the most frequently used antimicrobials. The physician's suspicion that a child's infection may be bacterial should be aroused when the onset of the infection is abrupt, the child is toxic appearing

and his fever quite high, and the upper respiratory signs appear after the onset of the fever and toxicity. Infants under the age of one often respond with the same signs and symptoms to both bacterial and viral agents.

Therefore, it is important for infants in the first year of life and older children, suspected of having a bacterial infection, to have a nasopharyngeal or throat culture. Generally, one may wait 24 hours for the results of the culture before starting antibiotics provided that the parents are observant and report any change in the child's condition.

In almost all uncomplicated acute upper respiratory tract infections in childhood, antibiotics are neither useful nor indicated. Therefore, the treatment becomes symptomatic. Aspirin in the dosage of one grain for each year of age to age five may be used to lower the fever and relieve the discomfort. Nose drops are especially helpful in shrinking the nasal mucosa of the nursing infant and in relieving the older child of discomfort. An ephedrine-like nose drop at one-quarter adult strength is adequate. Often, the first instillation shrinks only the anterior mucosa and it is helpful to provide within five to ten minutes a second instillation to shrink the posterior portion of the nasal mucosa. If thick mucus is a problem, then plain saline dropped into the nares has a liquifying effect. Suction bulbs which tend to annoy the infant and may, when used frequently, tend to create more mucosal edema should not be used. Cough mixtures and syrups may have a benefit in liquifying secretions but those containing antihistamine preparations tend to cause drying of the mucosal surface creating thick mucus which is hard to propel.



Acute Herpetic Gingivostomatitis

A good examination of a child always includes close inspection of the mucus membranes of the oral cavity including the gingivae. By retracting the cheeks, first one side and then the other with a tongue blade and with the aid of a good light, lesions on the mucosa of the lips, cheeks and the gums can be seen. A majority of acute ulcerative lesions seen in this area are due to the herpes simplex virus, with the exception of the newborn period when the curd-like lesions of moniliasis are most common. Acute herpetic gingivostomatitis, as a primary infection, is the most common oral lesion during the years of one to three, although it can be seen into adulthood. The symptoms are fever, salivation, pain, foul odor of the breath, and refusal to eat or drink. The oral lesions are located on the tongue, cheeks and gingiva and consist of vesicles, ulcers covered with a grey membrane, and gingivitis. Cervical adenopathy is most often present. The febrile course may last as long as seven to ten days with temperature elevations as high as 105 F. Because it is a self-limited disease, the treatment is symptomatic, maintaining hydration and nutrition through the use of iced fluids, jello, chilled fruits and ice cream.

Herpangina

Herpangina is an acute disease often occurring in epidemics during the warm weather. It is caused by certain Coxsackie group A viruses and is characterized by oropharyngeal lesions. Following an incubation period of about four days, fever as high as 105 F and a sore throat occur.

Examination shows characteristic discrete lesions located usually on the anterior pillars but also on the uvula and soft palate. These lesions

are first vesicles which quickly ulcerate and have a surrounding area of hyperemia. The white blood count is usually normal or slightly elevated. The course of fever and ulcerations lasts from four to seven days and the disease is self-limited. Treatment is symptomatic maintaining hydration and keeping the temperature under control. Iced fluids and a chilled soft diet is usually accepted more readily by the affected children.

Acute Tonsillopharyngitis

Some inflammation of the tonsils and pharynx is seen in about all respiratory tract infections, but included here are those conditions in which the major manifestations of inflammation are in the tonsillopharyngeal region. Acute tonsillopharyngitis with or without exudate can be caused by Beta hemolytic streptococcus, adenoviruses, Corynebacterium diptheriae, infectious mononucleosis and others. It is impossible to distinguish accurately and regularly between viral and bacterial infections by direct inspection only. Because of this difficulty and the importance of treating Beta hemolytic streptococcal infections, it becomes necessary to culture each patient with this condition for Beta hemolytic streptococcus. If the throat culture is positive, then treatment may be instituted and other members of the family cultured. This may seem a formidable task to the busy practitioner who has never attempted this daily procedure—too time consuming to fit into the over-worked day. However, the pay off in the freedom from worry of "having missed one" and in the satisfaction of knowing that one is not using antibiotics injudiciously can readily outweigh the trouble and extra time invested. A sterile cotton swab is applied to one tonsil and while gently and slowly twirled against the mucosa is moved in an arc along the soft palate to the opposite tonsil. The swab is then planted on a blood agar plate, which can be purchased for about ten-cents a plate, and the plate is streaked; the action of stabbing the agar at the end of streaking concentrates bacteria in the agar and will concentrate the beta hemolysis in a short time.

Following incubation for 24 hours, the plates are then read for beta or clear hemolysis. If the culture is positive, Penicillin is indicated and family contacts should be cultured. If beta hemolysis is not present, the infection is not due to Beta hemolytic streptococcus and is most likely viral in origin. Details in setting up the office procedures of culture technique for the detection of Beta hemolytic streptococcus are available from the local chapters of the American Heart Association.[4] Treatment consists of Benzathine Penicillin in one injection 600,000 units under 30 kg, 1,200,000 units over 30 kg of body weight. This is the most practical treatment because it is cheaper, convenient and it assures that the child has received adequate medication. If there is an allergy to Penicillin, then 50 mg/kg of Erythromycin daily in four divided doses for ten days is the drug of choice.

Infectious Croup

Any obstructive lesion in or around the area of the larynx is capable of producing inspiratory stridor or croup.

A careful look at the posterior pharynx of the restrained child will quickly reveal the presence or absence of acute epiglottitis. If the epiglottis is directly visible, swollen and beefy red, the child has acute epiglottitis. This condition is characterized by a rather sudden onset of painful swallowing, barky cough and inspiratory dyspnea, followed by fever. There may or may not be a history of prodromal rhinitis or cough. The usual cause of this disorder is H. influenzae type B and there is usually a bacteremia; in fact, the blood culture is more frequently positive than the throat culture. This condition is an acute emergency and the child should be hospitalized immediately for immediate intravenous fluids, intravenous Ampicillin, 200 mg/kg in four divided doses. A tracheostomy should be performed as a life-saving procedure and there should not be a delay in the decision to perform it.

If the epiglottis is not inflammed on examination of the pharynx, the child has acute laryngitis or acute laryngotrachitis. Here, there is usually a prodrome of a few hours to days of rhinitis, sneezing, and cough before the onset of the inspiratory stridor. Bacteria have been found to be the cause in less than 20% of the cases.[5] Viruses[6] more commonly found as the cause are the parainfluenza viruses, especially Type 1 and 2, the respiratory syncytial virus, influenza viruses, and adenoviruses. Antibiotics should be withheld until cultures are returned, unless the child has severe toxicity, high fever and leukocytosis. Treatment is symptomatic. Use the croup tent for relief of dyspnea and intravenous fluids if necessary.

Acute spasmodic laryngitis is the condition known as "midnight croup" which tends to recur in some children with each upper respiratory in-

fection during the preschool years. It is characterized by the sudden onset of inspiratory stridor a few hours after a child with a mild upper respiratory infection has been put to bed at night. Moist air seems to relieve the laryngeal edema and can be administered through the use of a vaporizer or by filling the closed bathroom full of steam. This condition is seen more frequently in those children who are easily excitable and in those children who, later, tend to have a higher incidence of respiratory allergies.

Acute Bronchiolitis

Acute bronchiolitis is an acute disease affecting children under the age of two, occurs in epidemics and is characterized by coryza of from one to a few days followed by acute respiratory distress wherein there occurs bronchiolar edema and infiltration; expiration is forced and prolonged; wheezing is evident on auscultation. The fever is low grade, usually less than 102 F and the white blood count is generally below 10,000/ml[3]. Chest X-ray shows overdistention of the lungs. Acute bronchiolitis is usually viral in origin and respiratory syncytial virus is the most common etiologic agent.[2] If the above findings are evident, then antibiotics are of no use. The child should be placed in high humidity atmosphere and carefully observed. Oxygen should be used when the accessory muscles of respiration are being used, which occurs before the advent of cyanosis. Intravenous fluids are usually required in the more severe cases. The use of epinephrine is not helpful and the use of steroids is under question at the moment.

Pneumonia

Pneumonia in childhood is classified in the usual fashion according to the anatomic distribution of the inflammatory response: namely, lobar pneumonia, bronchopneumonia and interstitial pneumonitis. The infectious agents responsible for the usual childhood pneumonias are listed in Table II. Lobar pneumonia is most frequently due to the pneumococcus; bronchopneumonia can be caused by any of the listed agents; interstitial pneumonitis is commonly associated with viruses. Regional obstructive emphysema with pneumatocoele formation is commonly due to the staphylococcus, although it has been seen at Children's Hospital of D.C. in the very young child with H. influenzae infection.

TABLE II
CAUSES OF PNEUMONIA IN CHILDHOOD

Bacterial
- **Pneumococcus**
- **Staphylococcus**
- **Streptococcus**
- **H. Influenzae**
- **Gram Negative Organisms (Neonate)**
- **Mycobacterium**

Mycoplasmal

Viral [2]
- **Adenovirus**
- **Influenza**
- **Para-influenza**
- **Respiratory Syncytial**

Rickettsial

Fungal

The clinical signs of pneumonia may vary according to the age of the child and to the causative agent. Generally, there is a preceding history of coryza, cough and fever of a few days with sudden onset of dyspnea, flaring of the alae nasi, and retractions. Auscultation of the chest may reveal findings which vary from normal breath sounds to the classic picture of lobar consolidation. Usually, however, there are fine to medium inspiratory rales.

The necessity of hospital care for a child with pneumonia depends on the appearance of the child and the ability of the family to observe changes in his clinical course. Dyspnea is usually an indication for hospitalization.

A nasopharyngeal culture should be obtained and a Tine test applied to the child's forearm. Symptomatic treatment is aimed at making the child comfortable with bed rest, a humidified atmosphere, oxygen if necessary, sponge baths and aspirin as needed for fever. Although it is being shown that viral pneumonia is much more common than previously thought,[2] most pediatricians, at this time, would agree that antibiotics should be administered while awaiting the results of the culture.

The child with pneumococcal pneumonia usually has an abrupt onset of high fever and dyspnea accompanied by a grunt at the end of a more shallow inspiration because of the associated pleuritic pain. Pneumococcal pneumonia responds dramatically to procaine penicillin, 600,000 units I.M. once daily, with rapid defervescence within 24 hours. The penicillin should be administered

either intramuscularly or orally for about five days.

Staphylococcal pneumonia should be suspected as the diagnosis of any child in the toddler age group or younger who presents with pneumonia. The finding of a pneumatocoele on the admission X-ray is good evidence of such; a family history of recent staphylococcal infection is also helpful. Following appropriate cultures, methicillin (Staphcillin) 200 mg/kg/day in four divided doses should be given intravenously until laboratory evidence assures that the staphylococcus is not penicillinase-producing. If it is not, penicillin should replace methicillin. The development of a tension pneumothorax from a ruptured pneumatocele is always a possibility. A thoracentesis set should be at the bedside and a thoracic surgery consultation obtained in all children with pneumatocele formation.

Gram negative organisms more commonly, but also gram positive organisms, cause pneumonia during the newborn period, when the incidence of a concomitant septicemia is very high. Following nasopharyngeal and blood cultures, ampicillin and kantrex, 15 mg/kg/day in two doses intramuscularly at 12 hour intervals is administered until the organism is identified and sensitivity studies dictate a change in therapy.

Mycoplasma pneumonia is more likely to cause pneumonia in the adolescent and adult members of the family than in infants and young children.[7] Nevertheless, during certain periods, 10% of all of the children hospitalized for bronchopneumonia at Children's Hospital of D.C. were found to have M. pneumonia infection.[2] Therapy in the childhood age group is erythromycin, 50 mg/kg/day in four divided doses and given orally. Tetracycline may be used in the older child and adults.

Otitis Media

Otitis media usually appears as a complication of an upper respiratory tract infection. A child appears at the doctor's office with one or many complaints—cough, some with fever, some without fever, hoarseness, restlessness, irritability, crying, and in infancy, trouble nursing. Only about one-fourth of children seen with otitis in one study [8] were old enough to localize pain in the ear. This disease is more common in the younger age group and is most commonly due to the pneumococcus, H. influenzae, or streptococcus. Viruses have been shown to cause otitis.[9, 10] Generally, the physical examination can be used as a guide for therapy. If the drum is diffusely red with normal landmarks and no bulging, no antibiotic treatment is required because it has been shown by aspiration that the middle ear is free of bacteria; if the drum has an absent light reflex, obliteration of the landmarks and is bulging, then antibiotic therapy is indicated. Ampicillin therapy, 100 mg/kg in four divided doses for ten days seems to work well because it is bacteriocidal against all three agents. However, it is still very expensive and can cause an aggravating diarrhea. One injection of Benzathine penicillin, 600,000 units under 30 kg, 1,200,000 units over 30 kg, will provide an adequate blood level for ten days against the pneumococci and the streptococci; and erythromycin or gantrisin can be given by mouth against H. influenzae. If there is a penicillin allergy, one must settle for bacteriostatic erythromycin, 50 mg/kg in four divided doses by mouth for ten days.

Tetracycline should not be administered in the young pediatric age group because of its tooth-staining properties. Many thousands of dollars



are going to be spent on children for cosmetic capping of their already ugly stained teeth. We do not need to perpetuate this. In addition to this fact, tetracycline in the usual dosages cannot be depended upon to reach an adequate therapeutic level in the middle ear secretion to eradicate the infection.[11] We seem to be seeing less children with prolonged serous otitis media since we have stopped using tetracycline.

It is important that each child with acute otitis media have a follow-up visit to assure eradication of the infection. Parents should bring the child back for examination during the second week and, if not cleared, the child should be seen weekly until cleared. With the realization that the treatment of each child with otitis media should be individually determined, a general guideline to therapy is as follows:

1. Mildly reddened eardrum with normal landmarks—no treatment.
2. Non-bulging eardrum with obliteration of landmarks—antibiotics; examine weekly until normal.
3. Bulging eardrum—myringotomy, culture, antibiotics.
4. Serous otitis—myringotomy; if fluid reaccumulates, consultation for possible insertion of tube.
5. Draining otitis through ruptured drum—culture, antibiotics; if not cleared in two weeks, X-ray of mastoids; consultation.



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DIAGNOSIS AND MANAGEMENT

The diagnosis of bronchial asthma is made on the clinical history and physical findings and by the exclusion of all other causes of "wheezing" in infancy and childhood.

Asthma is defined as a form of obstructive airway disease resulting from an antigen-antibody reaction producing an irritative tight cough, excess mucus, paroxysmal dyspnea, wheezing primarily expiratory and audible at the chest wall bilaterally. The antibody (reagin), having an affinity for the skin, the mucous membranes of the respiratory and gastrointestinal tract and conjunctiva, is referred to as skin sensitizing. The reagin or skin sensitizing antibody has certain distinguishing characteristics, i.e., can be passively transferred to the skin of a non-allergic primate (Prausnitz-Kustner reaction) except the guinea pig, is heat labile becoming inactivated at 56 C after two hours, can be detected by in vitro histamine release in the monkey ileum and by passive cutaneous anaphylaxis in the monkey and does not usually cross the placenta from mother to fetus. IgE recently has been suggested as the fraction containing the principal reaginic activity.

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Incidence

Asthma, hayfever and other allergic conditions account for one-third of all the chronic conditions occurring in children under 17 years of age. About 4.6 million children have some chronic allergy, 1.5 million with asthma.[1] These allergic conditions are distributed nearly equal in the pediatric population, i.e., 34.5% in the zero to four year age group, 33.7% in the five to nine year and 33.5% in the ten to fourteen year age group.[1]

Asthma is truly a pediatric problem. About 40% of the allergic children develop asthma by two years of age, 87% by seven years.[2] Eighty percent of the adult allergies had their origin in childhood.[3] In the light of certain statistics, asthma should be considered a preventable disease. Glaser states that 40% of the children with recurrent upper respiratory disorder and perennial allergic rhinitis develop asthma,[4] 30–60% having pollenosis develop asthma and 25% of these within two and one-half years of onset,[5] as high as 80% with eczema develop asthma.[6]

Diagnosis

The young pediatric asthma patient demonstrates a particular response. That immunologic competence develops within days is well known and consequently allergic manifestations may appear very early in infancy. This early competency is shown in Table I where it is noted that about 18% of the infants developed allergic symptoms prior to one month of age, 31% within one to three months and by six months 60% had demonstrated allergy which is to be compared with approximately 40% who manifested allergic symptoms between seven to twenty-four months.[7]

OF BRONCHIAL ASTHMA

TABLE I

AGE OF ONSET OF INITIAL ALLERGIC MANIFESTATIONS IN 103 INFANTS EVALUATED FOR ASTHMA

AGE	NO. OF PATIENTS
Less than 1 month	18
1–3	31
4–6	13
7–9	6
10–12	12
13–18	15
19–24	8

The initial allergic manifestations are listed in Table II. The most frequent early symptoms were related to the respiratory tract rather than the gastrointestinal although the allergen most likely was an ingested food.

The interval between the initial symptoms and onset of asthma may be extremely brief. In Table III it is seen that the majority of the infants developed asthma within a few days of their initial symptomatology, usually nasal symptoms.[7] If the asthma can be prevented then prophylactic measures as well as specific treatment must obviously be started early, that is, from birth and some aspects of treatment continued indefinitely.

The vast majority of these patients (males three: females one) gave a strong family history for allergy. Nonetheless it is significant that the median age of onset of asthma in both those with and without such a family history was the same, namely, 11 months. Thus a negative family history does not exclude allergy, and the infant from this family may manifest asthma just as early as one with a strong family history.

On physical examination the infant may be restless, apprehensive or lying quietly in the crib, exhausted, tachypneic. He cries or nurses for short periods, frequently stopping to recover from the dyspnea. The chest is hyperaerated. Because of the soft thoracic cage retractions are evident particularly at the xiphoid, subcostal, supraclavicular and suprasternal areas. Breathing is abdominal. There is flaring of the alae nasi and the breath sounds noisy, raspy, rattling. The character of the breath sounds on auscultation is dependent on the amount of air exchanged, the degree of airway obstruction and the amount of secretions. The expiratory breath sounds may be harsh, raspy; rhonchi transmitted over the entire chest from the trachea and larger bronchi; moist or dry inspiratory and expiratory rales; expiratory wheezing rales. When there is a severe degree of obstruction, breath sounds are so diminished that no rales are audible. This is the infant in serious trouble.

Other significant findings may include otitis media, the drums dull, injected or diffusely hyperemic or gray in color, bulging with or without a fluid level visible or retracted. Secretory or serous otitis media is a very common problem in the allergic child. The nasal mucous membranes may be pale or hyperemic, edematous. The nasal discharge may be scant or profuse, clear, watery or thick opaque white, yellow, or green in color. Pharyngeal lymphoid hypertrophy is usual.

TABLE II

INCIDENCE OF INITIAL MANIFESTATIONS LEADING TO ASTHMA IN 103 INFANTS

Initial Manifestation	Number of Patients
Respiratory	
Nasal	56
Asthma	20
Croup	4
Otic	3
Cough	2
Excess mucus	1
Bronchiolitis	1
Gastrointestinal	
Regurgitation	12
Colic	11
Constipation	3
Diarrhea	1
Skin	
Eczema	12
Angioedema	1

TABLE III

TIME INTERVAL BETWEEN INITIAL ALLERGIC SYMPTOMS AND ONSET OF ASTHMA IN 103 INFANTS

TIME	NO. OF PATIENTS
Few Days	52
Less than 1 month	5
1–3 months	15
4–6 months	11
7–12 months	8
13–18 months	7
19–24 months	5

In the past, these youngsters have had an adenotonsillectomy early, perhaps more than one, in the hope of alleviating the recurrent nasal, throat and ear complaints. It has been said that the child who has an adenotonsillectomy before three years or who requires more than one is allergic until proven otherwise.[8]

Asthma is a clinical diagnosis made after all other causes of wheezing have been ruled out. In Table IV are listed the numerous causes of wheezing in infancy.

TABLE IV

CAUSES OF WHEEZING IN INFANCY

I. *Respiratory System*
- A. Nasopharynx
  1. Mucus vibrating in passages
  2. Foreign body
  3. Tumors
     - a. Neoplasms
     - b. Hypertrophied tonsils, adenoids
  4. Inflammatory
     - a. Retropharyngeal abcess
     - b. Inflammation from inhalation—odors, gases, dusts.
- B. Larynx, Trachea, Main Bronchi
  1. Inflammatory
     - a. Croup
     - b. Laryngitis—diphtheria, croupous
     - c. Laryngotracheobronchitis
     - d. Bronchitis
     - e. Inhalation gases, odors, dusts
  2. Metabolic
     - a. Stridor of bronchotetany—rickets, hypocalcemia
  3. Allergic
     - a. Angioedema
  4. Neurologic
     - a. Paralysis vocal cords (recurrent laryngeal nerve) birth injury
  5. Traumatic
     - a. Dislocation or fixation of cricoarytenoid joint
  6. Foreign body
     - a. Larynx
  7. Tumor
     - a. Enlarged tracheobronchial nodes—Tbc. Hodgkin's
     - b. Enlarged thymus
     - c. Thymona
     - d. Substernal thyroid (lingual thyroid)
  8. Congenital
     - a. Long flaccid epiglottis
     - b. Laryngomalacia
     - c. Cysts—thyroglossal duct
     - d. Anomalous or redundant folds of mucous membrane
     - e. Bronchostenosis
     - f. Hemangioma—subglottic
     - g. Anomalous vessels—double aortic arch, vascular slings
     - h. Congenital web
     - i. Tracheal stenosis
     - j. Aneurysm—thoracic aorta, pulmonary artery
- C. Lesser Bronchi and Subdivisions (lungs)
  1. Foreign body
  2. Inflammatory
     - a. Bronchitis
     - b. Asthmatic bronchitis
     - c. Bronchiolitis
     - d. Inhalation of gases, odors, dusts, aspiration
     - e. Bronchiectasis
     - f. Cystic fibrosis
     - g. Pneucystis carinii pneumonia
  3. Tumors
  4. Bronchostenosis
  5. Emphysema
  6. Pneumothorax, hydrothorax
  7. Congenital
     - a. Lobar emphysema
     - b. Bronchopulmonary sequestration
  8. Miscellaneous
     - a. Loeffler's syndrome
     - b. Hamman-Rich syndrome
     - c. Periarteritis
     - d. Primary pulmonary obliterative vascular disease
     - e. Kartagener's syndrome
     - f. Wegener's granulomatosis
     - g. Dysautonomia

II. *Cardiovascular*
- 1. Cardiac asthma—secondary to congenital heart disease

III. *Central nervous system*
- 1. Functional or sighing dyspnea
- 2. Hyperventilation syndrome
- 3. Postencephalic hyperpnea
- 4. Stridor of cerebral palsy

IV. *Gastrointestinal*
- A. Esophagus
  1. Foreign body
  2. Esophageal pouch

Management

Skin testing: Once the diagnostic criteria have been satisfied, a long-term treatment program is planned beginning with skin testing. Hopefully the skin tests will provide the allergist with some clues as to the allergenic factors involved. The history, the patient's environment and physical findings will determine for which allergens the child is to be tested. Age is no contraindication to testing but admittedly the young infant does not demonstrate the same degree of skin reactivity as does the older child. Nonetheless a concerted effort must be made to determine the etiologic factor(s).

How are these skin tests to be interpreted? With the patient's history well in mind a negative reaction could almost exclude that allergen as a causative agent. For example, experience dictates that the child who develops asthma in late August or early September is very likely ragweed sensitized despite a negative skin test. A positive reaction may indicate previous sensitivity which may or may not have clinical significance at this time. It might suggest potential sensitivity, that is the child with only clinical ragweed pollenosis who shows on skin testing positive reactions to grasses and trees as well is likely to later develop pollen symptoms in the spring and early summer. The positive reaction may indicate present sensitivity. The actual clinical significance of the skin test reactions is determined by the patient's history or by clinical trial and observation.

Environmental control: This is an essential part of the treatment of every allergic patient. Not only are those environmental allergens avoided to which the child is clinically sensitive but also those to which he demonstrates positive skin reactions since such positive tests in the child should be considered as evidence of potential sensitivity.

Symptomatic: Having ascertained the severity of the asthma, presence or absence of infection, dehydration, the following routine is used to relieve the attack as promptly and as completely as possible.

I. Epinephrine (1:000) 0.10–0.25 subcutaneously and if necessary repeat every 15–20 minutes for 3–4 doses assuming, of course, that there is some improvement with the first injection. If the epinephrine is effective but too transitory give Susphrine 0.05–0.25 cc. subcutaneously every 6–10 hours as needed.

II. *Home care*

a) Antibiotics, chemotherapy if evidence of infection

b) Bed rest

c) Force fluids—clear liquids

d) Nasal decongestant—nose drops (Neosynephrine 0.25%, Otrivin 0.05%, Afrin 0.05% but not those containing antibiotics, sulfa or antihistamines), Sudafed or elixir Neosynephrine.
This may be unnecessary in that during the time that the asthma is at its peak the nasal symptoms are minimal but as the asthma subsides nasal symptoms become more prominent. Furthermore, in the presence of asthma, antihistamines would not be used to control nasal symptoms. Antihistamines tend to make secretions thick and tenacious.

e) Bronchodilators — Inhalation — Epinephrine HCL (1:1000)—Isoproterenol (1:400) every 4–6 hours as needed. This would be used at the first sign of asthma, i.e., heaviness, tightness in the chest. When properly used this should bring prompt relief but relief may be transitory and therefore inhalation must be followed with additional medication. Inhalation may be used in between oral doses to minimize the asthma. As with all drugs intelligent use of sympathomimetics by inhalation is essential. Adverse effects (increased airway resistance, death) have been reported with the use of isoproterenol by inhalation.[9, 10]
Oral—Ephedrine, aminophylline or theophylline, isoproterenol or combinations thereof every 4–8–12 hours are prescribed until there has been no wheezing for 12–24 hours. When asthma is present during the day or during the previous night the patient is given medication at bedtime using a long-acting preparation such as aminophylline or theophyllin in liquid, capsule or enteric tablet or suppository form. By the appropriate timing of the longer acting drug it may be possible to control nocturnal asthma and the associated coughing. Sleep is less likely to be disturbed and the patient awakens in the morning with less accumulated mucus, wheezing and cough. Bedtime medication is continued until there has been no wheezing for 2–3 days. Care must be exercised with aminophylline or theophylline in that failure to recognize nausea, vomiting, headache, etc., as possibly indicating aminophylline poisoning could lead to serious complications. Young children may tolerate this drug poorly and to circumvent this problem the use of the drug is restricted to once a day at bedtime with ephedrine or isoproterenol syrup used every 4 hours as needed.

f) Expectorants—When wheezing has continued beyond 4 hours unrelieved, that is, persists

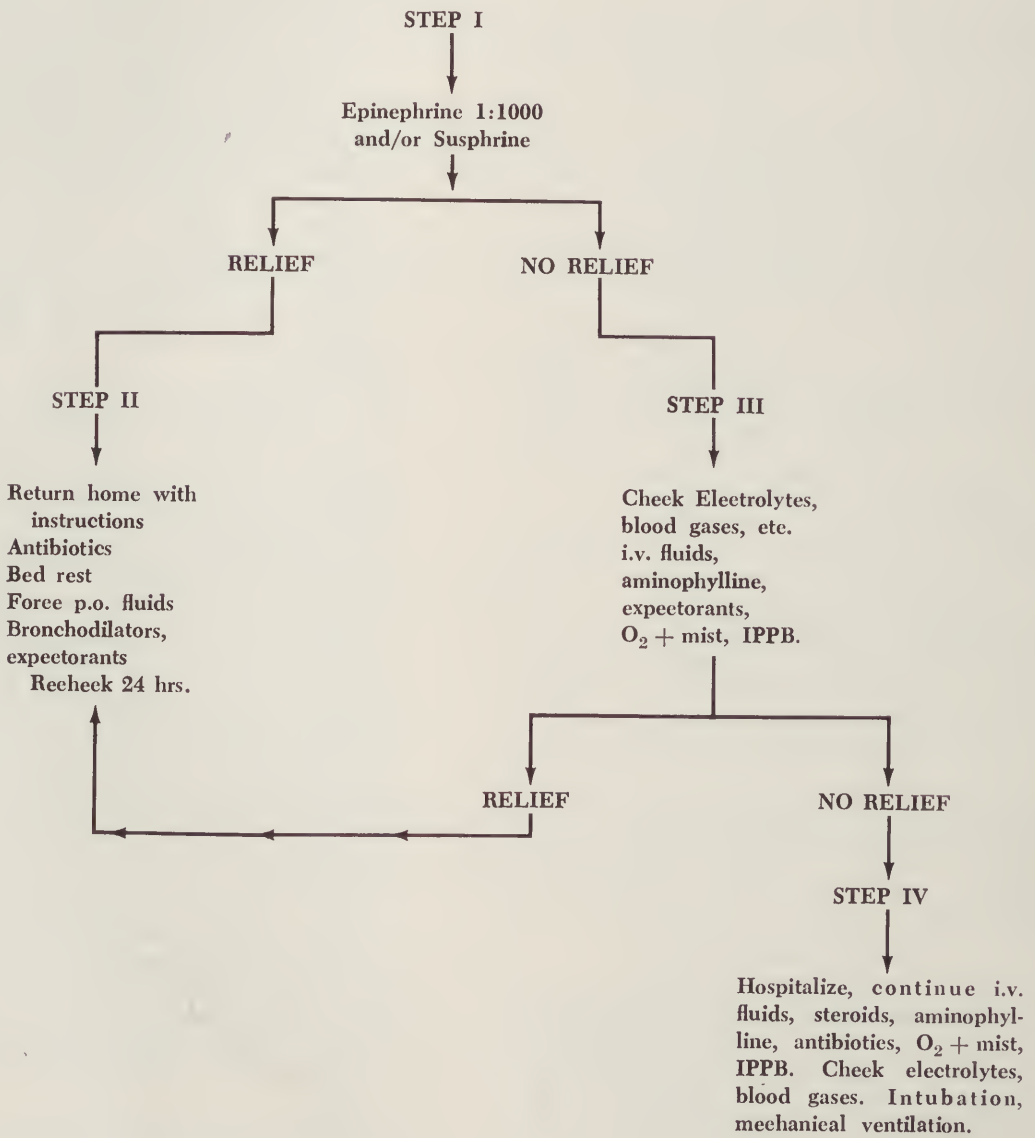
mildly but is not completely relieved, an expectorant is suggested such as saturated solution potassium iodide added to a large volume of beverage three times daily.

III. If the response to step #I is inadequate, intravenous fluid, usually 5% glucose in water, is started containing aminophylline and at the same time blood drawn for serum electrolytes, blood gases, hemoglobin or hematocrit, white cell count and patient strapped for urine collection. A chest X-ray is indicated at this point also. Depending on the severity of the attack and ability to cooperate intermittent positive pressure breathing may be appropriate. If the patient demonstrates a satisfactory response over the next 1–2 hours the initial intravenous fluids are completed and the patient is returned home and is to continue with instructions under step #II with reevaluation in 24 hours. A period of 12–48 hours may be allowed for full recovery.

IV. If there is no response to step #III hospitalization is usually indicated with intravenous fluids, aminophylline (3–6 mg./kg./day) and intermittent positive pressure continued; oxygen and mist, antibiotics, steroids added.

There is rarely a need for sedation. The child is apprehensive and restless because he cannot breathe. Thus relieving the respiratory distress will usually alleviate much of the anxiety and enable the exhausted patient to sleep.

The management of the acute asthmatic attack can be summarized as follows:



Instructions for managing the asthmatic attacks at home might read as follows:

I.

a) At the first sign of asthma (tightness, heaviness in chest and cough) use:

Epinephrine or isoproterenol spray every 4–6 hours as needed

When properly used this should bring prompt relief but relief may only be short lived and require repeating once or twice initially. Drink water after each inhalation. As soon as possible follow with:

b) Ephedrine or isoproterenol with or without barbiturate

If attack relieved completely within 30–60 minutes wait 4 hours and if no recurrence nothing more need be taken. If there is a suggestion of its return in 4 hours, however, repeat *ephedrine or isoproterenol* every 4 hours until relief is sustained, that is, until no wheezing for 12–24 hours. It may be necessary to use *spray* in between doses of *ephedrine or isoproterenol* to keep wheezing at a minimum.

II. When asthma present during day take the following at bedtime to prevent asthma from recurring during night and to reduce cough, wheezing, chest congestion in the morning:

Aminophylline or theophylline

III. When asthma lasts longer than 4–6 hours unrelieved, that is, persists mildly but yet not completely relieved begin:

Expectorant (sat. soln. KI)

Hyposensitization—Indications: When there is evidence from the history—with or without positive skin tests—of inhalant allergy due to pollens, molds or dust. Asthma is a cardinal indication for injection treatment. The dosage and concentration of allergy extract must be titrated to each patient's requirement, starting at the lowest dilution, gradually increasing the dosage and concentration until maximum tolerance is reached which is that dosage and concentration which most adequately control the allergic manifestations. Maximum dosage is continued weekly (extract being completely excreted within a matter of three to five days) during the period of the year when the patient experiences his difficulty but again always titrating the frequency to his need. When the patient remains completely asymptomatic throughout the entire year on a four-week injection schedule hyposensitization can be discontinued.

Hyposensitization to be effective demands a great deal of understanding, thought and close observation. It is indeed time consuming. It is important to understand that the patient is receiving in the allergy extract the allergen(s) to which he is clinically sensitive so that untoward reactions are a distinct possibility and therefore the extract must be administered with care watching for significant local or systemic reactions as the physician attempts to reach the appropriate dosage. Reactions are not an indication for stopping the injections but merely requires reducing the dosage and/or concentration. What constitutes a significant reaction?

Local—Itching, redness, swelling, soreness, 3–4 cm. or more lasting longer than a few hours occurring with each injection which has been given by the same technique on each occasion.

Systemic—Usually manifested by development of original allergic signs and symptoms, e.g. urticaria, pruritis, angioedema, nasal and/or eye symptoms, cough, tightness or heaviness in the chest, wheezing usually within minutes and certainly within 24–48 hours postinjection. The time interval between injection and onset of symptomatology is generally the same after each injection.

The patient's tolerance may change at any time during his course of treatment so that close observation and accurate reporting is mandatory. The child with continuous or frequent asthma or recurrent respiratory infections presents a problem in that the patient and the physician are reluctant to proceed with injection therapy for fear of aggravating the situation. Having carefully assessed the situation and determined that the extract is not at fault, the hyposensitization must be carried out on a regular basis if one is to expect results. At present multiple injection therapy with aqueous extract is still the method of choice.

Gamma Globulin: It is tempting to consider using injections of gamma globulin at four to six week intervals for the young child with repeated respiratory infections associated with asthma and whose serum gamma globulin is perhaps in the lower range of normal. Its use in asthma is not indicated not only because of its ineffectiveness, but also repeated injections may produce anti-gamma globulin antibodies which have been implicated in the severe clinical reactions to gamma globulin and which might neutralize the effectiveness of gamma globulin therapy.

Steroids: There is general agreement that the acute asthmatic attack which has not responded to epinephrine, fluid therapy and aminophylline should be treated with steroids. The duration of the attack is not necessarily important in determining the severity of the attack. Some episodes may be life threatening from the outset or the moderately severe attack present for many hours or days may have so exhausted the patient as to suppress the cough and cause further retention of mucus. Whether the patient is already receiving maintenance steroid therapy or not the initial steroid regimen is the same, a loading dose is required. Since steroids may not produce the desired effect for several hours, i.e. as long as 24 hours, it is imperative that therapy be started early. On the other hand the patient may so improve from a single intravenous dose that no additional steroid therapy is required, but in such case one would have to question the necessity of steroid in the first place.

Assuming the patient is receiving intravenous fluid therapy the suggested steroid regimen would be as follows:

1. **Hydrocortisone Na succinate 50–200 mg. directly i.v. every 6 hours until marked improvement is noted then follow orally.**
2. **Prednisone (1–2 mg/kg./day) e.g. 15 mg. every 8 hours, until chest is practically clear. If patient has not previously received steroid the dosage may then be tapered rapidly and discontinued in 4–5 days. The patient previously on maintenance therapy will be tapered rapidly to just above his previous maintenance level with further reduction attempted at 1–2 week intervals. During the tapering process should wheezing recur the reduction in dosage is slowed and the number of days at each level increased. Nonsteroid (ephedrine, aminophylline, isoproterenol) medications are reintroduced with the tapering of the steroids.**

Long-term maintenance steroid therapy is indicated when the usual medications do not adequately control the disease to the extent that the usual activities appropriate for the patient's age are disrupted. Once the criteria for long-term steroid therapy has been satisfied the patient is started on a sufficient amount initially to control symptoms followed by graduated reductions to near physiologic (5–10 mg daily) levels or the lowest possible dosage which with other symptomatic medications will provide maximum control.

Prednisone is the steroid of choice since ACTH suppression is of shorter duration with this steroid, e.g., one and one-half days compared to two and three-fourths days for dexamethasone. Some long termers may benefit from dexamethasone aerosol in that less oral steroid may be required. However, it is well to remember that adrenocortical suppression may result from as little as four inhalants per day. The dosage of nebulized dexamethasone must be carefully calculated and never on a "PRN" basis.

The timing of the steroid dosage is important. To minimize adrenocortical suppression the maintenance dose should be given:

1. **Total dosage every other day in the morning or if not possible to adequately control asthma then**
2. **Total dose once daily in the morning. Some patients on alternate day therapy may obtain better control with less prednisone with ACTH gel at monthly intervals.**

Another steroid, an anabolic agent, oxandrolone (Anavar) shows promise in the management of the asthmatic requiring long-term steroid therapy. Although the mechanism is unknown oxandrolone (0.25 mg/kg/day) may allow use of a smaller maintenance dose of Prednisone thus reducing some of the side effects, particularly in the child that of growth retardation. Oxandrolone has been shown to stimulate growth under this circumstance.

Prognosis in Asthma

It is difficult to give an accurate prognosis in asthma because of the numerous variables such as severity of the disease, methods used in case reporting, duration of follow-up, type of treatment, etc.

Statistics are of little value in prognosticating the course of an asthmatic child. This child having demonstrated the ability to become allergic is destined to remain at least potentially allergic for his lifetime. The allergen, the "shock organ" may change with time but the basic underlying immunologic defect remains. In general terms what are the chances of "outgrowing" asthma without hyposensitization? Flenborg [11] reported 40% of 300 asthmatic, free of asthma after an average follow-up of seven and one-half years. Johnstone [12] followed 91 asthmatics until their sixteenth birthday, 18% were asymptomatic at that age. In addition Johnstone found no significant effect of age of onset or severity at onset, presence of other allergic disease (a history of pollenosis giving a poorer prognosis than eczema or combination of eczema and pollenosis with asthma), presence of multiple sensitivities, duration of the disease before adequate treatment is commenced.

Results in terms of "cure" in patients given

hyposensitization (together with environmental control measures and symptomatic medication) range from 30–50% and with an equal percentage at least improved. Although there may not be complete recovery the likelihood of improvement is better with adequate treatment.

With the available knowledge, what is to be done for the allergic or the potentially allergic child? Whatever the problem a concerted effort should be made to determine the allergen and treat appropriately. This may merely require substituting soybean (not goat, powdered or boiled, skimmed cow milk) for the milk formula to alleviate the colic, regurgitation, eczema, and excess mucus developing in the neonatal period. The incidence of allergic reaction is higher with lactoglobulin and lactalbumin than with casein so that heat-treated milk will take care of many milk allergies but the physician should go a step further by eliminating milk completely and thereby avoid challenging the allergic infant with casein, a potent antigen, which is heat stable. Soybean would be the formula of choice. Clinical allergy to soybean is extremely rare. Every allergic child should be placed in an allergen free environment. The child cannot become sensitized to feathers if there are no such epidermoids in the household.

Where there is a strong family history of allergy in the parents and/or siblings it would be appropriate to provide the expectant mother with a special diet avoiding excessive intake of milk and egg, eliminating any known offending foods and controlling any other allergic problems in the mother as well as delaying the introduction of baby foods until three months of age and then offering one new food at a time. To illustrate the proposed plan as first suggested by Glaser:[13]

SUGGESTIONS FOR THE DIETARY MANAGEMENT DURING THE FIRST YEAR OF LIFE

1. **Breast and/or soybean feedings using a soybean formula of 10 oz. of soybean milk plus 20 oz. cooled boiled water if formula used as supplementary feeding. If used as regular formula use soybean full strength, i.e., 15 oz. soybean liquid and 15 oz. cooled boiled water. If at all possible attempt to give infant only the breast or soybean formula for the first three months.**
2. **When starting baby foods begin with the vegetables or fruits first giving in this order: carrot, string bean, squash, white potato, pea, beet, cauliflower, sweet potato, spinach. Give the fruits in the order of apple, banana, pear, peach, apricot, plum, prune. Each of the above foods would be added to the diet at an interval of every 7 days during which time careful note is made to determine if the newly added food causes any disagreement.**
3. **At about 5 months meat may be added into the diet in this order: lamb, veal, pork, ham, chicken (capon, male fowl), beef and when infant has adequate number of teeth for chewing add bacon.**
4. **At 6 months of age may add cereal in this order: rice, barley, oat, corn. If these are well tolerated the flour of these various grains may then be used in preparation of other food items.**
5. **Citrus fruit (orange, lime, lemon, tangerine, grapefruit) may be added at 9 months followed by wheat, in the form of a pure cereal such as Cream of Wheat, and egg at 11 months in the form of hard boiled eggyolk first and hard boiled eggwhite next and finally plain whole cow's milk at 12 months of age.**

CARE MUST BE TAKEN TO READ CAREFULLY ALL LABELS ON THE FOODS TO MAKE CERTAIN THAT THEY DO NOT CONTAIN UNDESIRED INGREDIENTS. IF THERE IS ANY QUESTION AS TO THE CONTENTS IT IS BEST NOT TO USE. MIXTURES OF VARIOUS FRUITS, VEGETABLES, MEATS CANNOT BE USED UNTIL EACH INDIVIDUAL FOOD IN THAT MIXTURE HAS BEEN TRIED SUCCESSFULLY.

Glaser reported only 15% of his prophylactically treated infants developed major allergic disease during a follow-up of seven months to ten years compared to 64% of the sibling control group and 52% in the non-related subject control group. In a similar type of study Johnstone[14] showed a significant reduction in the incidence of perennial allergic rhinitis up to the age of six years and a lower incidence of asthma in the age group from birth to three years.

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THE ROLE OF THE FAMILY
PREVENTION OF EMOTIONAL

One of the most striking phenomena of modern times is the interest in mental health and mental illness. Several recent studies indicate that between 10 to 20% of our population suffers from some form of emotional disorder. The type of disorder runs the whole gamut ranging from psychotic illness, delinquency, character problems, psychosomatic illness, to neurotic and behavioral disturbances. This prevalence applies also to children and adolescents.

Faced with such an enormous number (at least 20 million) of emotionally disturbed people of all ages, one must ask whether this is an integral part of our modern life, or whether we now pay more attention to problems which have always existed. Unfortunately, it is almost impossible to make meaningful comparisons since in the past the study of emotional problems was relegated to poets rather than physicians and there is little documentary evidence on the prevalence of emotional disorders in human history.

Some people consider the high frequency of emotional disorders in children as a purely American phenomenon. Yet there are reports from other technologically advanced countries, such as Sweden and Great Britain, indicating that they too are grappling with very similar problems.

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To tackle such a large group of emotionally disturbed children is an enormous task and we seem, at the moment, rather poorly equipped to handle it. To begin with, we lack the manpower. To treat some five-million youngsters in this country we have only about 1,500 child psychiatrists, most of whom practice only on a part-time basis. Our child guidance clinics which are designed to look after the less affluent are woefully understaffed and waiting lists often stretch to one year or more. There are still many counties which do not have even a single psychiatrist or child guidance clinic. The use of psychologists in psychiatric treatment helps somewhat to fill this tremendous gap, but the demand for services to emotionally disturbed children grows almost in geometric progression while the appropriate services can barely keep up with an algebraic one. In addition, present methods of psychiatric treatment seem inadequate for a large proportion of disturbed children. The traditional psychotherapy is of greatest benefit in neurotic and behavioral disorders and about two-thirds of this group will show improvement following treatment. Psychotherapy, however, has made little progress into the problems of childhood psychosis, delinquency and other personality disorders. It seems that the main way of improving the mental health of our children is prevention rather than treatment.

In the process of prevention, the family physicians and pediatricians play the most important role since they are placed in the strategically ad-

PHYSICIAN IN THE DISORDERS IN CHILDREN



vantageous position of being able to detect trouble at the earliest stage before it has mushroomed into a serious problem. It is universally agreed that the younger the child and the shorter the duration of emotional disturbance, the more effective will be the therapeutic intervention.

A family physician would be better equipped for this important task if he were given clear guidelines on spotting potential danger signals.

Pregnancy and Postpartum Period

The preventive approach ideally should begin before the child is born—during pregnancy. There are several studies which link maternal depression and anxiety during pregnancy to a variety of obstetrical difficulties such as nausea, pre-eclampsia and eclampsia, spontaneous abortion, prematurity, and complicated delivery. None of these studies have established beyond any doubt the causal rather than temporal connection of emotional and physical disorders during pregnancy, but some are quite suggestive. The existence of serious emotional and physical symptoms during the gestational period should make one suspicious about the prospective mother having some conflict regarding her mothering role. If unresolved, such a conflict may adversely affect the mother's attitude toward the baby. Routine obstetrical care during pregnancy should include observation of the mother's emotional state, and in particular, her feelings

about the prospect of a new baby. As is true in all emotional disorders, the mother may not volunteer such information unless specifically asked about it. In most cases the doubts and conflicts are only mild and one or several sessions with the prospective mother (and in some cases with the prospective father present) will suffice to ensure her emotional well-being during pregnancy.

Group meetings of pregnant women, led by physicians, have been introduced with great success. These group discussions facilitate the ventilation of feelings, and the group's support and tolerance are of enormous help to the individual prospective mother.

The two to three months following delivery represent another crucial period when some help offered by the physician can go a long way. The mother is physically and emotionally exhausted by the ordeal of pregnancy and delivery. In addition, her body undergoes rapid changes involving many systems, particularly the endocrinological ones. A relation of the latter to emotional states, though not completely understood, seems clearly established today. The young mother often responds by a resurgence of dependency needs and the desire to be cared for. Instead, she is called upon to muster all her strength, to repress or deny her own powerful dependency needs, and to take care of a new baby who demands attention practically around the clock, is relatively unresponsive, and offers little immediate reward to the mother. This is a supreme task which separates the women from the girls (i.e., the less mature individuals) and it explains the very high incidence of emotional disorders in the postpartum period ranging from simple "postpartum blues" to a full-blown postpartum psychosis.

This maternal vulnerability, while presenting hazards, also greatly facilitates therapeutic intervention. At no other time is a woman as receptive to empathy and emotional support as during the period following delivery. Ventilation of self-doubt, resentment, and other "undesirable" feelings to an empathetic physician who can clarify and calmly reassure is often all that is needed. Should such an emotional support not be available, whether it comes from a physician, a friend, or a relative, the seed for future conflict may be planted.

Some of the early manifestations of tension in the mother—and often in the father—are symptoms seen in the baby, such as colic, sleep disturbances, and excessive irritability. Nobody has as yet offered a clear-cut explanation of the colic phenomenon, but many studies imply that tension within the family is one of the major causes. There is nothing more humiliating for a physician than to admit a colicky baby to the hospital after some five or ten successive antispasmodic or tranquilizing medications failed to bring relief. What almost invariably happens is that the baby quiets down immediately after admission and the physician becomes the target of derision by an indignant hospital staff for admitting a perfectly normal baby as an emergency case.

The time spent on the telephone discussing a colicky baby with frantic parents may often be more profitably spent on an interview with both parents in an effort to bring to light existing family tensions, and to offer reassurance about the relative brevity of this disorder, as well as advice on possible arrangements which would afford the parents periodic relief and proper sleep. Attention to parental needs assuages their guilt feelings and permits them to function calmly and more effectively, to the great benefit of the baby and the future parent-child relationship.

The First Year of Life

Among psychiatric theorists, diversity rather than unity is the rule. However, most of them agree that the first year of life is probably the most important to the future mental health of an individual. In order to function effectively in society, the child has to get along with other people. The foundation for such future social interaction is laid in the first year of life and the mother-child relationship is its cornerstone.

At birth, the baby is an unrelated individual and the process of socialization progresses gradually, characterized by several clearly recognizable steps. One of the first of such steps is the *development of smiling*. The baby begins to smile toward the end of the second month and by the end of the third month this response is fully established. The baby initiates smiling spontaneously, but the response elicited from its environment will largely determine the maintenance and reinforcement of smiling. The baby will smile, and later "coo" to a human face more readily than to inanimate objects.

At first this smiling and cooing is indiscriminate. Anyone approaching the baby at this age in a gentle manner will be rewarded. No wonder it is such a pleasure to examine a three-month-old infant who smiles at the physician even while the latter prepares his syringe for vaccination!

Between the fourth and sixth months the baby gradually learns to discriminate between people and to recognize his mother as a separate and distinct entity. The *recognition of mother* is manifested in his joy when she approaches, expressed in intensified smiling and cooing and in increased motor activity such as kicking.

Following this stage, the baby develops between the sixth and ninth months what is known as *stranger anxiety*. He no longer smiles and responds to just anybody who approaches him and views the physician with suspicion and often with fear. Concomitantly, he develops *separation anxiety* and manifests displeasure whenever the mother is out of sight. At the same time he also familiarizes himself with his father and siblings so that by the end of the first year he becomes a well related member of the family.

Searching for evidence of success in passing the above-mentioned stages of early socialization should be a standard part of well-baby care. Failure to pass these stages within more or less normal limits may often presage future difficulty. For example, the failure to develop a smiling response may be the first indication of mental retardation, peripheral or cortical blindness, or even of autism which is an early form of childhood psychosis characterized by an inability to relate to people. On the other hand it may also be the result of neglect and, especially, of lack of stimulation from the environment. Extreme cases of environmental deprivation leading to a gradual extinguishing of the smiling response are seen in institutions, but less extreme forms may be found in well-educated families if a mother is emotionally poorly equipped to care for her baby and finds little pleasure in this process. Since the mother's availability is so important in the first year of life, she should be discouraged by the physician from working outside of the home during this period unless there are really compelling financial reasons. In such cases, a carefully chosen baby-sitter may help to avert trouble.

The child's failure to develop fear of strangers or separation anxiety often indicates a tenuous mother-child relationship or one that is not well established. Studies of institutionalized infants and toddlers indicate that they form attachments to complete strangers very easily. These attachments, however, are very superficial and lack genuine depth.

One significant group of infants who have trouble establishing a meaningful tie with their mothers are those with isolated organic handicaps. Their response threshold is either too high or too low, they may be constitutionally hyper- or hypoactive, or their neurophysiological homeostasis may be easily disturbed.

Let us take a hypothetical infant who has a very low threshold for tactile or auditory stimuli. Each time he is picked up energetically by his mother he experiences physical discomfort, thus preventing his enjoyment of his mother's touch. Instead of molding his body to that of his mother, he cries and stiffens up. Another child may become uncomfortable and cry whenever his mother speaks loudly or sings to him. We can well imagine the mother's frustration and disappointment when her approaches are repeatedly rebuffed by the baby. This would be a case of a *rejected* rather than rejecting mother. Some women may instinctively and correctly preceive the child's idiosyncrasies and adapt themselves accordingly; some will intensify their efforts and aggravate the situation by increasing irritability in the child; others will finally give up and reduce contact with the baby to an absolute minimum. The latter two courses of action may be quite disastrous since they preclude the formation of a comfortable mother-child relationship.

Only by routine investigation of a baby's response to a variety of sensory stimuli of differing intensity can the physician ascertain the presence of such handicaps when there are no specific parental complaints. Such problems are often easily solved by a modification of the sensory stimulus. The mother will be advised to diminish or increase the intensity of a given sensory modality. If a baby dislikes to be picked up, she may attempt to maintain contact by talking to him or playing with him without picking him up too frequently or too brusquely. In the case of an infant who seems over-irritable on a constitutional basis, a judicious use of medication such as some antihistamines or one of the so-called minor tranquilizers may greatly aid the parents in accepting the child more comfortably.

During this period of infancy, mothers will betray some of their own negative feelings toward, or anxiety about, the child in a variety of ways. In order for the physician to respond appropriately to these disguised distress signals, it is useful for him to familiarize himself with them. Of the common ones is the exaggerated concern over the

child's physical health. We are all familiar with a mother who calls anxiously several times a week, describing with great urgency what seems to be a very benign and mild condition such as a common cold or a rash. If the mother is an intelligent woman and the frequency of phone calls does not decrease after the physician's explanations, we may be dealing with a person in distress. There may be some disagreement between her and her husband, a resentment towards her mother-in-law, or anxiety about the child developing some illness which had previously occurred in her family. At any rate, she does have a problem which causes depression or anxiety; yet she may not want to talk about it directly, being perhaps unsure that her physician would want to listen to her; or, she may feel that everyone should keep his problems to himself without burdening someone else. In many cases a single lengthy discussion may suffice to establish communication and consequently bring relief through release of pent-up feelings. Sometimes several talks with the mother or both parents, together with a few common-sense suggestions, are needed to eliminate a potential source of friction.

The Toddler Years

The first year of life is decisive to the child's ability to relate comfortably to people and to his establishment of basic trust in them. In the second and third years of life the central tasks are: *the beginning of autonomy and independence* and *the capacity to accept restraints on one's inner impulses.*

Toward the end of the first year, the infant acquires mobility. This allows him to enlarge the scope of his activities and is coupled with an intensive drive to explore and to experiment. The symbiotic bond between mother and child begins to loosen and at this stage children begin to move away from their mothers, gradually increasing the distance. When closely observed, children in these years often seem oblivious to their mother's presence. However, every once in a while they return to mother for emotional "refuelling" during which periods they seem to regress to a very dependent behavior and again enjoy being "babied" and cuddled by their mothers. Most mothers can accept these temporary returns to infantile behavior as a normal part of growing up so that they meet wholeheartedly the child's dependency needs; some mothers, however, are less flexible and find it difficult to accept these temporary regressions.



This is especially true of women who prefer to take care of older children rather than infants. Instead of responding appropriately to the child who seeks their individual attention, they push him away, scold him, and/or taunt him for being "babyish". In extreme cases the mother is so eager for the child to grow up and be independent of her that she begins to make arrangements for nursery school practically as soon as the child is beginning to walk.

The results of such failure to respond to the child's dependency needs at this stage of development, and the premature push towards independence, may be quite disastrous. In examining cases of adult depressive illness, evidences have been found of early childhood trauma involving separation and rejection. Some believe that the second year of life is crucial in this respect, and that children whose mothers fail to perceive and respond correctly to their intermittent need for closeness during this period become predisposed to depression in later years.

The toddler age also marks the beginning of *impulse control.* There are two basic urges which parents seek to constrain: the urge to eliminate bodily wastes and the urge to destroy property. There are several factors which will determine the success of such parental effort to "civilize" the

growing child. The better the understanding between mother and child in the preceding stages of development the easier it is for the child to conform to mother's wishes; and the more intellectually and neurophysiologically the child matures the easier it is to train him. Some studies show that toilet training started around one year of age may require six to eight months for its completion, whereas the same process started at age two may require only one month.

In the past, early toilet training was considered very harmful and a precursor of psychopathological distortions, especially in the development of obsessive-compulsive personality traits. Available evidence, however, does not support such a global assumption. It may be safely stated that even today the majority of mothers all over the world begin toilet training very early by our standards—somewhere around one year of age. Yet proof is lacking that the prevalence of mental disorders in other countries is higher than in the United States where late start of toilet training is the rule.

What probably matters is not the timing but the mother's attitude in the process of toilet training. In a culture such as ours where a permissive approach is prevalent, the mother who deviates from this norm is likely to be harsh and strict in general, and may pressure the child prematurely into more conforming behavior, squelching any sign of resistance. Such an attitude may result in one of two kinds of disturbances: The child may fully conform and give up any attempts toward independent thinking and action, with serious consequences to his emotional maturity; or a running battle between mother and child may ensue, resulting in an exaggerated negativistic attitude on the part of the toddler which, in the long run, will impede the process of his socialization.

The physician may help by routinely inquiring about habit training during this period. He may gently "put on the brakes" on a mother who is over-zealous. Often an authoritative statement about the timing of an attitude during toilet training, and also about making the house "childproof" by putting away expensive breakable items until the child is older, will suffice to prevent a serious family crisis. Of course we have to be equally cautious about a mother who is overly permissive thus unduly delaying the introduction of restraints. If a normal child still nurses a bottle at the age of two, or is not toilet trained by the age of three, we should explore with the mother her rearing methods. We may find that this mother has difficulty in "depriving" her child of any gratification because of her own background. She may simply repeat the pattern used by her own mother; or she may resent her own harsh and deprived childhood and be determined to make up for it with her own child. Talking about it to a sympathetic listener will help the mother to put the past and present in proper perspective. Thus we may prevent the development of a child without proper impulse controls which will be handicapping in any social situation, especially during the school years.

The role of the family physician does not stop after the periods of infancy and early childhood, when the precursors of future personality gradually emerge, but continues throughout childhood and adolescence. Worthy of mention are several special situations which warrant increased alertness on the part of the family physician because of their high risk of emotional disturbance.

Adopted Children

Every practicing child psychiatrist sees and treats more adopted children than one would expect. This is the distinct clinical impression of most people in our field, although systematic studies are lacking. Since adopted children come from diverse backgrounds, their emotional vulnerability can hardly be explained by genetic constitutional factors. Rather, we should look for the cause in the attitudes of adoptive parents.

Adoption, even to the most enlightened people, represents a certain trauma, a blow to their self-esteem by underscoring an inadequacy in a very important human function. Added to this is the knowledge of illegitimacy in most children available for adoption. The resulting feelings of resentment toward the child are seldom brought out into the open except in a parent counseling situation.

Most adopted children seen professionally for reasons of emotional problems, have been reared in an overly permissive rather than harsh and strict way. We can only speculate that the parents lean over backwards to be "extra nice" to the adopted child in order to assuage guilt feelings caused by their resentment.

The prevention of emotional difficulties should ideally start before adoption takes place. Prospective adoptive parents should be carefully evaluated

as to their emotional stability and should be given an opportunity to freely express their feelings regarding the adoption. When freed of their guilt feelings, parents of adopted children will be able to exercise their obligations without any special considerations, thereby instituting firm limits and consistent guidelines of behavior as the child grows older. The family physician may want to spend more time than usual with the adopted child and his parents, inquiring about his adjustment in greater detail. The younger the adopted child, the easier it is to correct faulty habits and attitudes.

Chronic Handicapping Diseases

Children with chronic physical or mental disorders are much more prone to emotional disturbance than normal children. These conditions include mental retardation, cerebral palsy, cystic fibrosis, hemophilia, congenital heart disease, and many others. Most people are able to meet various crises in life—including the fact of having a chronically ill child—with great resilience; many however, experience shock and disorganization following the diagnosis of a major physical or mental handicap. The period following consultation and diagnosis is extremely crucial and often has a decisive influence on the whole course of events in the future, particularly on parental handling and management of the child. Parents may receive emotional support from someone within their own family, from each other, from their own parents, from a clergyman, or from their friends. Often, because of weakening family ties in our modern times, many people are really quite alone during this trying period.

If there is nobody to fill the void, the role of the family physician becomes crucial. He can intervene very effectively and help the parents with clarification, reassurance, support, and by letting them know that they do not have to carry their burden alone because he is there to guide them to the best of his abilities. This usually decreases parental tension and anxiety which will then enable the parents to treat their children as normally as their condition will allow.

One should be particularly alert about the two extremes of parental attitudes in such cases: *rejection and over-indulgence.* If uncorrected, both may result in serious emotional disorder in addition to the pre-existing physical one. Our own studies of children with cystic fibrosis and congenital amputation lead us to believe that the emotional adjustment of a chronically ill child depends primarily on the parents' attitudes rather than on the severity of the physical illness.

Hospitalization

Hospitalization is especially traumatic to children between the ages of six months and three years. Their main concern is about the separation from the family and familiar home surroundings. One may often trace a beginning emotional disorder to a hospitalization in early childhood. Awareness of this danger may guide family physicians in preventive measures. If at all possible, one should avoid *elective* hospitalization during these early years; and, if the child is hospitalized, we should make every effort to have his mother and/or father with him for as long as possible, preferably around the clock. In case of parental unavailability, for whatever reason, one should mobilize hospital personnel such as nurses, nurses' aides, occupational therapists, volunteers, etc., to give the child a lot of individual attention. This would be more effective if *one* person could be assigned to the child to ensure a continuous relationship rather than a rapid succession of caretakers. Finally, in case of surgery or other traumatic procedures, we should always attempt to prepare the child at the level of his intellectual functioning. Handled in this fashion, a hospitalization may often turn out to be a maturing rather than a regressive experience.

Practical Considerations

One often finds that the average family physician is well aware of certain emotional hazards in his patients and their families, but feels helpless in dealing with them either because of lack of time or lack of training.

Time Factor: Admittedly, psychological counseling is time-consuming, but so are many other medical procedures. The family physician obviously spends much more time on a work-up of chronic heart failure than he does on removing wax from a child's ear. Evaluation and counseling in an emotional disorder has to be elevated to the status of other complex clinical problems. One practical solution successfully used by many family physicians is to set aside one morning or afternoon session each week specifically to deal with incipient emotional problems in half-hourly or hourly interviews. Experience shows that parents are willing to compensate the physician appropriately for his time if duly forewarned about it.

Competence: Prevention of the family physician's inefficiency and lack of knowledge relating to psychological matters should start in medical school and continue in the years of internship and residency. Some people are "born psychiatrists" and have the flexibility and skill to elicit feelings and attitudes in an effortless way. Most of us, however, are not as fortunate and need guidance and proper training. No family physician will practice obstetrics or surgery without appropriate background and training in these disciplines. None will learn how to read ECG's or X-rays correctly without suitable preparation under supervision. We cannot exempt psychotherapy or counseling from this principle. Since most family physicians are forced to deal with many emotional problems regardless of their personal preference, they might as well be equipped for this task.

A period of three to six months spent in a combined adult and child psychiatry setting during residency may well prepare the potential family physician to do supportive therapy and counseling when he goes into practice—above all, to be able to detect signs of impending difficulties before they develop into full-blown disorders. The needs of family physicians already in practice can best be served by on-going post-graduate courses and seminars neatly balanced between theoretical and practical considerations. A fine model of such a program was developed by Dr. Balint of the Tavistock Clinic in London. In his seminars the participating physicians present and discuss their own cases and receive appropriate guidance. Such an approach through active participation of the family physician seems most effective, and now is being introduced in this country by the general practitioners program of the American Psychiatric Association.

Community Resources: In many cases the family physician may not be able to cope with the problem because of its complexity. He may then call on members of other professions such as Social Service, Psychology, etc., to help him. In order to do so, he should be familiar with the existing family agencies and other mental health facilities in his area. If such services do not exist or are of poor quality, it behooves the family physician to be in the forefront of community efforts to create or upgrade existing facilities. Some may prefer to band together and hire a social worker or psychologist to be available for their private cases. This approach may have a lot of merit, provided the physician does not abrogate his responsibility and remains the central figure in each case.

The above-mentioned solutions are only a few of many effective ones. The main point is to clearly recognize the role of the family physician in the prevention of emotional disorders in children. Once alerted, the family physician will be able to cope as successfully with this aspect of his medical practice as he does with many others equally as complex.





It has been said the issue in the physician's role in sex education is not whether he has a part to play, but whether or not he chooses to play it well. It is becoming increasingly apparent that patients expect physicians to be competent guides concerning sexual matters; whether the physicians like the idea or not.

The physician *should* have a leading role in sex education, but only as he clearly understands the role of the educator. The primary aim of the educator is to provide factual information, and his eventual goal should be to produce an individual willing and able to process these basic facts in order to arrive at conclusions in harmony with the actual situation. So the physician's first role in sex education is to become educated—this should include all facets of sexuality, and the education must encompass the idea that sexuality includes more than genital union or other erotic stimulation. It must be based on the promise that sex is inextricably woven into all phases of living—the bio-physiologic, psychologic, and sociologic aspects.

THE ROLE OF THE PHYSICIAN IN SEX EDUCATION

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Experts have divided the physician's role in sex education into three sections:

First—as physician-advisor to every patient whom he sees, the physician has the opportunity to give information, correct fallacious attitudes and inculcate the idea that sexuality is a part of every human life.

Second—as a physician-teacher he can enlighten students on the anatomy, physiology, and psychology of sex from his advantageous position of knowledge and authority.

Third—as physician-consultant he can give information and alleviate the anxieties of teachers, ministers, and lay leaders of the community who are more frequently in direct contact with the students.

The physician's primary goal is not only to relieve the symptoms of disease and injury, but to prevent them. He has the same responsibility in the role of sex educator. When he treats the sexual aspects of living as normal physiologic processes he automatically begins sex education. When he dispenses correct information and guidance in a totally non-judgmental fashion he is fulfilling his role of sex educator.

The increasing need for sex education has grown out of the refusal of many American parents to deal realistically with this subject in the home, and of the clergy to do so in the church, and of the physician to do so in his office. The results of this failure can be seen in almost every community in teen-age pregnancies, a growing incidence of homosexuality, and emotionally disturbed young people, and the irresponsible activity of people in mass media who use the exploitive aspects of sex to make money. There is far greater need for sex education today than ever before.

We are living in what might be called a sex-centric society wherein we are being pummeled every hour of the day, every day of the year with sex stimuli through radio, TV, movies, paperbacks, ads. On the other hand, our young people

are being pressured by parents, teachers, clergy, and even the legislators to abstain from all this activity. This creates a great many problems and anxieties—our young people must make more moral decisions through their teen years than their grandparents did in a lifetime—and it isn't easy. This society is not of their making, it's of our generation's making, and we must be responsible for teaching them how to cope with it.

In the role of physician-advisor, we have a responsibility to our own private or clinic patients with whom we come in contact on a more or less regular basis. Our responsibility should start with the needs of the infant, but an infant has parents who play an essential role in the child's development; so as we care for the growing infant in our offices we must counsel the parents—and here may be our most important role, for sex education starts at birth.

It is in infancy that our sex attitudes are being formed. All of us have been exposed to some form of sex education, whether we are aware of it or not. Some of us may have had a rather negative education that has produced feelings of disgust, shame or guilt; others have had a sex education that has produced feelings of wholesomeness, naturalness, and even a reverence for our Creator. Most people have had a little of both and are trying to keep them in balance.

Sex education happens naturally in 1001 different ways. It includes much more than the answer to the old question, "Where do babies come from?" Everything that happens to a boy to make him glad he's a *male,* and will one day be a husband and a father, is *good sex education.* The same thing is true for a girl. Anything that will help her fit into the woman's role happily and naturally is *good sex education.* If you can get this idea across to parents, you will have accomplished a lot. If you can quiet the woman who chronically complains to her children what a rough life she leads, that her children are a plague and a nuisance, and housework is a drudge, you will have helped her daughters' growth to maturity immeasurably.

Even when you are a baby, the way you are cared for shapes your love-life in years to come. In infancy you first learn what love is and you respond to the warmth of another human being. The way your mother held you, fed you, and dressed you communicated this feeling of love or rejection. Young parents must understand how their basic attitudes can either help these youngsters into stable maturity or turn them into neurotic weaklings. A child can form sexual attitudes and behavior patterns far more easily from what his parents *do,* than from what they *say.*

All that one learns about love in infancy is through bodily contact—a language you could understand long before you could understand the spoken word. Facial expressions and attitudes are sensed by a child long before he can talk. During toilet training days, many children get the idea that their bodily functions are dirty and unclean. When mother makes an unpleasant face when changing a diaper, baby soon feels this is a nasty part of the body—so anything connected with that area has an unclean tag on it. If you can teach mothers to train their children lovingly, with remarks like, "Do this for mother," then the child has a sense of elation with his bodily functions. If the toilet training is too harsh or hard, the child may give out in angry spurts of diarrhea; or, hold back in spite—creating constipation.

When any curiosity about the genital area of the child is met with a hush-hush attitude, embarrassment, or corporal punishment, this tells the child this area is taboo. Parents must be informed how to deal with this problem. They must know that most psychologists estimate that 90% of the boys masturbate at one time or another, and 60% of the girls. So it is a common behavior pattern. The physician in dealing with the mother who asks about her child's interest in masturbation cannot merely say scientifically there is nothing to worry about with masturbation, for it is a normal outlet of sexual tension and a normal result of childhood self-exploration, but he must also note the mother's anxiety about the problem, and probe into her attitudes, and then teach her that *her* fears are more significant than the child's behavior. She must realize that such behavior in the infant is sheer exploration, as in discovering the fingers, toes, et al. Then in their pre-school loneliness it is again common. These early experiences help to lay the basis for future acceptance of sex as desirable and pleasureable, unless of course, the child is led by parents' negative reactions to view them as shameful and degrading.

During adolescence, masturbation and its attendant fantasies may not only be a means of releasing sex tension, but often serves as part of the adolescent struggle to achieve a sense of identity and a sexual self-image. Masturbation in

adolescence, on the other hand, may be a symptom of many non-sexual conflicts. Boredom, frustration, loneliness, poor self-image, inadequate boy-girl relationships, conflict with parents, too many school pressures, etc., can all create tensions that the adolescent tries to relieve through masturbation.

It is our responsibility to convey to parents the knowledge that masturbation itself produces none of the harmful physical or mental affects about which physicians used to warn in years gone by. Untold numbers of persons have suffered mental turmoil because of a sense of guilt about their practice of masturbation. For some, this turmoil has resulted in psychological damage. This psychological damage is not caused by the act of masturbation itself, but by the feeling of guilt that they have violated a strong cultural, moral, or religious ethic. So our parents must know that masturbation in itself is not harmful, but if practiced in excess, it may suggest the presence of other problems that the individual is unable to handle. One mother complained that her ten-year-old boy constantly masturbated. Questioning revealed that because the boy had failed to learn basic play and sport skills, he was constantly teased and ridiculed when he attempted to play with other children. Thus he failed to acquire appropriate social skills, with the result that the range of expected sources of satisfaction in his life was restricted. Individual work with a physical educator soon led to his acquisition of play and sport skills and paved the way for acceptable social play with his peers and the symptoms subsided. Clearly his *excessive* masturbation had been the *symptom* of a problem, rather than the problem itself.

A sixteen-year-old girl came to me in tears because she had masturbated during the time of her puberty, and she was afraid she would not be able to have a normal marriage, or even have a family. I could assure her that there is no evidence that masturbation in youth reduced satisfaction in marriage for either the male or female.

From a strictly medical and mental health point of view, there is no reason to try and prevent masturbation. Parents are best advised to disregard evidence of private masturbation in juveniles, and as with other bodily functions, young children can be helped to become aware of the distinction between what is acceptable as public and as private behavior, without implying the



private behavior must be in any way bad. Full and accurate information about masturbation should be given to both parents and children, and it is our job to give it. In such discussions a simple, non-judgmental informative approach and manner will do much to dissipate the fears and anxieties about it that are so commonly found to block the road to mature acceptance of oneself as a sexual being.

Children quickly pick up their parents' attitudes toward sex. How they feel about nudity, how they feel about their mates. Knowledge about the physical facts and sexual techniques is not enough. Sexual adjustment is not sex alone, it includes these emotional attitudes from childhood. A father can teach his son a good attitude toward sex by the consideration he shows his wife. A mother can teach her daughter about sex by the respect and admiration she shows her husband. This is sex education in its very best form, and until this is driven home to our parents, we will continue to have an increase in the number of neurotic young people in our communities.

Dr. Mary Calderone said, "What is done in the first eight years of life determines one's attitude toward sex for the rest of one's life. When there is gross delinquency in a youngster, there is *most* often a disturbed home situation." She stressed that men should recognize the critical role they play during the first eight years of their

child's life. Their attitudes and actions are most impressive.

A father can easily convey to his son the *Playboy* Philosophy of Sex that Hugh Heffner has foisted on the American Public in exchange for millions of dollars. This magazine teaches our boys very vividly that woman is a mere pleasure tool of the man, and that man's sexuality is to be used for conquest—not as a means of conveying affection. Too many marriages reflect this very attitude. Mr. Heffner denies the fulfillment that goes with marriage, and conveys the idea that marriage is the very worst thing that can happen to man. It's interesting to note that he is a bachelor, and never has been married. Here is where the attitude of the adults determines the values of the young which in turn determines their behavior.

Homosexuality is another facet of life about which we should be giving advice. It's worth noting that there is wide agreement today that man from birth does not possess an instinctive desire to achieve any specific goal in regard to sex, but that his sexual behavior is at any time the cumulative result of the learning and conditioning experiences he has had. Homosexuality is widespread in our society, figures indicate this. Between adolescence and old age, about 37% of all males have had some overt homosexual experience to the point of orgasm, and about one-half of the males who remain unmarried at 35 have homosexual experience. For females, the estimated incidence of homosexual behavior is about one-half that of the male.

The obviously effeminate male or mannish female homosexual constitute only a small fraction of the homosexual population. By and large they are no different physically from individuals with normal impulses. The opinion of psychiatrists and psychologists is sharply divided on the question of whether or not homosexuality is a symptom of emotional disturbance. The opinion most commonly accepted is that homosexuals are emotionally ill or neurotic. Others says this behavior is not the result of emotional disturbance, but rather a result of the direct conditioning effects of the person's early experiences. Many psychiatrists feel that aside from the sexual maladaptation, it is perfectly possible for a homosexual to be happy and to make a good social adjustment.

According to prevailing psycho-analytic opinion, homosexuality represents a failure of the child to proceed as normally expected through the oral, anal, and genital stages of development, and thus it represents a fixation at, or a regression to, an immature stage of development.

It is important to realize that many individuals during adolescence go through a stage of homosexual behavior or play, and then go on to complete heterosexual adjustment. There is agreement among authorities in the field that genetic, constitutional, or glandular factors play little role in the causation of homosexuality, whereas psychological, social, and cultural factors do play key roles.

Many factors cooperate in producing homosexuality. Among these are inappropriate identification with the opposite-sexed parent, fear or hostility of either parent, reversal of the masculine and feminine roles in parents, cultural overemphasis on the stereotype of masculinity which produces feelings of inadequacy in males who are not able to fulfill this expectation, easier access to sexual gratification with members of one's own sex in adolescence resulting in habit patterns that persist. Studies indicate that a disturbed parent-child relationship is a key factor. Especially the combination of a seductive or over-attached mother and an absent, weak, or rejecting father.

Experts say preventive efforts should focus on:

1. Creating a climate of opinion that will allow homosexuality to be openly and reasonably discussed, and objectively handled.
2. Providing adequate sex education of both parents and children, so that the homosexual can understand himself better and the community can free itself of its punitive attitudes to all sexuality.
3. Increasing efforts to provide family counseling and child guidance not only to promote healthy family life, but also to provide specific advice for parents whose children show early signs of development difficulties before these become fixed.

It is important to counsel especially with the father to give more attention to his son, to be a real father image for his son to emulate. If there is no father, encourage activities under some responsible male—scout leader, teacher, coach, music teacher, boys' club activities, etc.

When you are examining your young patients who are approaching puberty and you notice the

development of secondary sex characteristics, it will seem natural to make inquiries about their sexuality—have you begun to menstruate yet? Do you know what this means, why it occurs? Explain menstruation with a chart. Reinforce what she has learned in school. Show her you are able to talk about such things. After examining, ask mother to wait in the waiting room while you talk to daughter. Ask if she is happy? Anything bothering her? Any pressures from school? How is your social life? Are you dating? How much? Is there anything you want to discuss?

The same rule should apply when boys begin to show the development of secondary sex characteristics. Ask if they have had any noctural emission or wet dreams as yet. Explain what they are, how they are usually accompanied by erotic dreams to trigger the process so they may get rid of the seminal products they have been manufacturing. Explain that this is a part of healthy growth and development and is nothing to feel guilty about. This is the reason they don't *have* to have sexual intercourse in order to release the accumulation of sperm, it is a natural, normal built-in release for these products.

As you see these young people in their regular examinations through the years, you can ask about their problems and volunteer information. You will find young people will talk more readily and naturally than adults if you give them an opening. When you are stripping the urethra during a routine exam, you can explain about VD, what symptoms to look for, how it is acquired, and advise that they should come to you if they even suspect trouble.

In both boys and girls you can get across the idea that sex is an expression of one's total personality. You can tell them about the thin fellow, not husky enough for the school teams, who tries to prove his masculinity in the back seat of the car. Or the girl who, in rebelling against overly dominant parents, may get pregnant to get out from under the yoke. Middle-aged persons who are disappointed in life, may seek a sexual fling to bolster their shrinking self-esteem.

Sex does not depend on knowledge alone, although many marital fears and failures are based on ignorance. Young people at every age need appropriate information. It behooves us to ask questions, and listen carefully to what they are trying to tell us. If their questions seem precocious, we must remember that they are living in a culture we adults created for them. If they know enough to ask the question, they are entitled to the right answers. We must remember that sex involves not only reproduction, but also the social roles



we've built around being a man or a woman. Research shows that sex experimentation begins in Junior High, and older folks who say these young people are too young to discuss these things, simply do not know today's youth.

When these young people start to date it's important for them to realize the strength of their sex drives. They will be on the road to understanding sexuality, when they learn that mature love is giving of one's self to another, not the idea of using another person for one's own self-gratification. Sex is not an end in itself, it is a means to an end of expressing one of life's finest emotions.

We do find the teen-age youngster coming to the physician's office with a multitude of vague somatic complaints which really are signals that he wants to know about himself. If the doctor is intuitive in such matters, he may pick up clues and gradually lead the adolescent into a discussion about himself. If, on the other hand, he merely takes the somatic complaints at face value, he will miss the entire reason for which the adolescent came. Where you suspect your patient may be anticipating pre-marital sexual relations or is already sexually active; it is important for the physician to give these young people the necessary background to help them think it out. We have only one life to live, and it is up to each one of us to determine what kind of life that will be. It is important for young people to know there can be no mental health without self-respect.

Research done among psychiatrists on college campuses has shown that there is more mental illness among our college youth today than ever before, and the greatest single contributing factor was found to be pre-marital sexual experience. This sort of thing proves to be very stressful, for society imposes social stresses upon the permissive girl which are sufficiently painful to drive the co-ed to mental illness. The sexually permissive girl comes to see herself as more of an object to be *used,* and less of an equal partner, so that her self-image is gradually eroded and finally completely destroyed. We must help college students understand that sex is more than a plaything, more than a self-indulgence—it is a function that can contribute to the growth of character and maturity. It can make possible the transformation of an egocentric child into a mature adult.

Physicians need to help parents to understand that they can help children by building their self-esteem and self-confidence. The child, especially the young girl, who has a solid feeling of self worth and popularity has a much easier time in deciding what she will do about her sexual behavior. The insecure, less socially successful girl who doesn't make friends easily often finds that she must choose between being promiscuous in order to have the male attention she so eagerly craves, and a "holier than thou" sort of prudery. Helping a child to build social skills and self-confidence is an important part of a child's "Sex Education." It is our responsibility to point this out to parents.

Fear of pregnancy and VD is not a healthy basis for the development of a sexual philosophy. You probably have all been asked at one time or another to prescribe "the pills" for a teen-ager who may claim terrible menstrual problems or a marriage date two months hence; so it is up to you to determine which is the greater evil, the pre-marital relations or the unwanted child.

The pre-marital exam should be considered a privilege as well as a duty for the physician to make available to each bride and groom as an adequate and realistic examination. Just an STS, and a hearty congratulation are neither realistic nor



adequate. The pre-marital exam should include a review of the systems, a reproductive history, an adequate physical exam and pelvic exam, and contraceptive methods, explained, discussed, and dispensed. Finally there should be pre-marital counseling for both bride and groom.

If coitus has not been initiated, she must be assured that her marital relations should be entered into joyfully and wholeheartedly. Explain that it takes a very mature person who has been brought up in a very "proper" way, to make a complete turnabout after the marriage ceremony and give of herself freely and without restraint. It is important that they understand there is no such thing as perversion in marriage, as long as both parties are satisfied. Mature love is like a good wine, if properly tended it will improve with age.

There are several ways in which the physician-teacher can help with sex education at large. He can, and should, lend his community prestige to the promotion of sex education and family-life education courses in the schools. These new courses help young people explore attitudes and values as well as physiology and function. These classes may encourage communication about sexual problems between children and their parents.

Most school systems are following a pretty basic pattern in sex education. In the kindergarten the children are given to understand that life comes from life, and they have the opportunity to plant flower and vegetable seeds and watch them sprout and grow. In the first couple of grades they have the pregnant guinea pigs and hamsters in class—so they will learn that every animal reproduces its own kind. Later they learn that in all animal life there must be a father *and* a mother before reproduction can occur. In later elementary years they learn that all animals develop from eggs, and that the eggs are within the mother, and the sperm in the father, and they must join before the egg can start to develop into a baby. In the sixth grade the focus switches from animals to humans, and the function of the ovaries, testes, sperm and eggs is explained.

Sex education was mandatory in the Baltimore City elementary schools this past year, and physicians were called in as expert consultants to train teachers in how to handle the subject. Now they are training the Junior High teachers for next year, here the emphasis is on inter-personal relations, and the normalcy of their own sex interests. High School will follow with discussions of VD, Homosexuality, Family Planning, and marriage preparation, for one must prepare these young people for *all* of life, and sex education should be an integral part of the child's education to prepare him for adult responsibilities.

Circumstances may dictate that the physician serve as consultant and advisor to teachers, ministers, and other lay leaders who are doing the actual instruction. Some physicians are more comfortable in this category, than in doing the actual teaching. Many of you have probably been called upon by innumerable PTA's to explain to the parents why there should be a sex education course in the schools. In this way you are helping to create a climate in the community, where parents will be prepared to accept the courses.

Many physicians have worked with the Family Life Committees in the religious faiths, trying to find ways to inculcate this information into their existing programs. We have held ten-week seminar sessions for the clergy of all faiths in order to develop a deeper understanding of human sexuality. We have taken part in workshops for nurses, social workers, medical educators, etc., to give them more insight and understanding of the sexual problems they meet. We have even arranged a series of sessions for the Girl Scout adult administrators and leaders, so they in turn could be more enlightened and able to discuss problems with the girls under their influence.

It is only by an adequate program of sex education that we can combat the distorted view of life our children are receiving from TV, movies and magazines where broken marriages, prostitution, adultery are all so blatantly portrayed as the usual way of life.

In a resourceful role, the physician can assist the community leaders in recognition of the growth patterns of children, stressing that the sexual aspect cannot be separated from physical, intellectual, social, and emotional development. Through sensitivity to the diverse cultural backgrounds that have preceded the school years, foundations for mutual respect, and self value can become a primary force in sex education.

Today's physician can no longer remain enshrined within his office in a one-to-one relationship. Community and social involvements are almost impossible to avoid. Sex education should become one of the physician's major contacts with the community.

your medical faculty at work

by John Sargeant
Executive Secretary

The Executive Committee met on Thursday, July 18, 1968, and took the following actions:

1. Rescinded suspension of a physician's membership on the basis that the suspension would create a medical hardship in the member's community; and placed that same member's privileges on probation for a two-year period.

2. Authorized the inclusion of a reservation blank for the Maryland Medical Political Action Committee Semiannual Meeting luncheon in the same envelope with the Faculty's other social function reservations.

3. Approved a request from the Program and Arrangements Committee to change the format of the Exhibitor's Annual Meeting reception to another type of "social affair."

4. Authorized the President to name a Faculty representative to serve on the Local Arrangements Committee of the Annual Meeting of the American Association for the History of Medicine.

5. Approved a request to the Prince George's County Medical Society for such society to seek approval on release of unclaimed animals from that local pound to research activity.

The weekend of February 10 and 11, 1968 was a disappointing time to the members of the American Academy of General Practice, when the Liaison Committee of the Advisory Board for Medical Specialties and the Council of Medical Education of the AMA deferred to an indefinite date the formation of an AMERICAN BOARD OF FAMILY PRACTICE. The weekend of May 25 and 26, 1968, also was a disappointment to many of us, when the Congress of Delegates of the American Academy of General Practice failed, by two votes, to accept a new Classification of Membership—A Fellow of the American Academy of General Practice. Thus two votes short of the required two-thirds majority, prevented some form of internal certification of Quality Training, and Experience, to indicate that applicants had passed a Comprehensive Examination based on Residency Training Orientation or Practice Orientation.

CERTIFICATION AND THE GENERAL PRACTITIONER

What does this mean? Apparently slightly better than one-third of the Delegates feel that an additional classification is not needed. They say that this would make two classes of General Practitioners of Medicine, the certified and the uncertified.

Certification, or issuance of a certificate, can be described in this case, by two definitions: (1) a document showing completion of a course of study, not leading to a diploma, or (2) a document authorizing some professional pursuit.

Therefore, what does certification mean? It simply means that the applicant has successfully completed a course of continuing education of a quality nature that is residency oriented or practice oriented; and has completed a comprehensive examination in this training, given by either the American Academy of General Practice or the American Board of Family Physicians.

Therefore, our Academy must continue to seek means, and this probably will be by re-introduction of the Fellowship Classification Amendment, to offer this certification to the applicant.

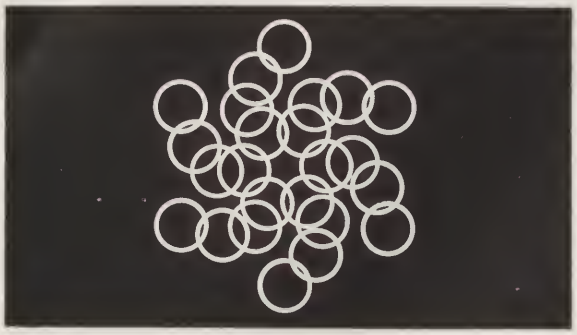
Really, the most important aspect of the entire problem is Quality Control of the programs and proper diversification of subject or discipline of training. *The certifying agency is the one that sets the standards, and we,* as experienced, knowledgeable Practitioners, *must be the ones that set these standards* and guidance for those who are to follow us. It is our responsibility to set high goals, to see that these are maintained, and added to, as our knowledge increases, so that the Practitioner of the future will meet his responsibilities to the citizens of our country, to render Quality Medical Care.

All of us practice General Medicine, because this is what we want to do. We prefer not to be esoteric in our approach, we prefer to treat the patient as a whole, and to look at him as a member of his environment—his family relationships, his personal problems, and developmental problems.

In summary: Some form of certification is necessary. That this certification must be under the direct control of the American Academy of General Practice; that this certification can be accomplished by Quality Programs of continuing Education, that are Residency Oriented, or Practice Oriented; that the American Academy of General Practice must continue to maintain leadership in this vital role of continued education is a vital necessity.

Therefore, it becomes incumbent upon us to aid those who will follow us, to afford them an opportunity to obtain quality in their training that we, as experienced practitioners, have learned through the years; and to ensure that our National Academy, The American Academy of General Practice, shall become the certifying body.

ARCHIE ROBERT COHEN, MD
Clear Spring, Maryland



From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

alcoholism section

First Year Review of Alcoholism Program, Tuberculosis Division, Baltimore City Hospitals

A formal program directed towards alcoholism has been used in the TB Division of Baltimore City Hospitals since May 1, 1967. This evaluation includes an exploration of the development of the program over a one-year period.

Alcoholism has been an important disease on the wards at Baltimore City Hospitals for many years. During the 1950's the late John O. Neustadt, MD, reviewed admissions to the Acute Medical Service and found at least 40% of the patients had alcoholism as part of their diagnosis. Later, from 1962 through April 1966, interviews of 552 patients on admission to the TB Division revealed that more than 50% admitted to moderate to heavy drinking or had a history of arrests or hospital treatment for alcoholism.

EDMUND G. BEACHAM, MD
Chief, Tuberculosis Division
Baltimore City Hospitals

During 1962-6 most acute and many chronic alcoholics received sedation and tranquilizing medication and most had individual psychiatric evaluation. There was no group therapy practiced during this time and no AA meetings were attempted in the hospital. Most effort was spent in identifying the problem and trying to work out solutions through the physician, nurse, social worker, patient and family if possible. Special efforts were made to return patients with drinking problems to as stable and sober a community environment as possible. We felt we did not return more than 25% of our alcoholics to sobriety in the community.

The Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of Maryland, the State Department of Mental Hygiene, and then the Governor's Committee on Tuberculosis Control all supported a view that alcoholism and tubercu-

losis created special problems that might well be worked on together in a Tuberculosis Hospital. Our Division sponsored a meeting of State and City official health and welfare agencies in February 1967 to discuss movement of alcoholic-TB patients into the community. Our staff, including medical social workers and psychiatrists, were given four lectures on alcoholism through the State Department of Mental Hygiene. The Maryland Tuberculosis Association then awarded us $3,500 for a one-year program to demonstrate the use of a recovering alcoholic as a part-time counselor in the Tuberculosis Division.

Our first counselor participated in the above-mentioned lectures, then on May 1, 1967, began to work with us. He was assigned an office on the Ambulatory Male Ward to work directly under our Associate Chief Physician. He was given an orientation by the physicians, nurses, and social workers and introduced to all our patients. An Alcoholism Advisory Board consisting of the Chief and Associate Chief of Service, Chief TB Nurse, Director and TB Supervisor of the Department of Medical Social Work, and Chief of Adult Psychiatry met with our counselor twice monthly for the first few months and monthly since then.

The counselor saw patients on referral from physicians, nurses, and social workers as well as working closely on his assigned ward. He turned in a daily diary of activities (to the Chief of Service) and kept a record of consultative services. He worked closely with the Social Work Supervisor. During the first six months about 60 new patients were interviewed.

Ward meetings were arranged for our four groups of physicians, nurses, and ward personnel; then after October, 1967 individual patient problems were discussed with ward personnel at the time of occurrence of the problems. The counselor participated in our weekly Family-Patient Conferences at which time he was introduced to persons having alcoholism who were under consideration for return home.

Alcoholics Anonymous meetings were started May, 1967 as a weekly program. They have been most successful with an average of 25 patients attending through the year under counselor support. In October, 1967 the Division was accepted as an Institutional Member of AA and has AA groups rotate in presenting meetings.

The counselor helped patients to recognize the signs and symptoms of alcoholism, to discuss all aspects on a practical basis, and to accept the disease as a problem. He offered a listening ear and offered help, by way of example, in the ability to recover. He encouraged use of AA, the Alcoholism Clinic, and the many hospital opportunities to begin to tie together helpful parts of their lives and families. He was regular and frequent in visits to all patients who were willing to or wanted to see him and became a full-fledged therapeutic staff member. He functioned well as a person who understood the language of the patients and offered additional liaison between them and the staff.

At time of discharge, until January 1968, alcoholism patients were referred to the Baltimore City Health Department Alcoholism Clinic. A. M. Schneidmuhl, MD, Director of the Alcoholism Clinic, reviewed a list of 130 discharges from May-September 1967 and found that of the 60 patients referred with drinking problems, only nine came to the Clinic and only three visited more than once.

Our original counselor was not able to continue after November, 1967 but we began to work with students of the new Alcoholism Counselor Course of the Alcoholism Center. During December 1967, we had one student full-time and during January and February 1968 we had two students full-time. Since then Mr. William Black, our first student, returned as a graduate and was our counselor through the remaining two months.

In January, 1968, we began to use Antabuse. After consultation with Dr. Schneidmuhl we decided to use it for patients just before return to the community and for it to be continued in the Alcoholism Clinic. At the same time we began to send patients with the counselor to the Alcoholism Clinic prior to discharge, for initial interviews and orientation. We have sent about 20 patients through this pre-discharge formula, some having multiple clinic visits before discharge. Only six patients have had Antabuse prescribed in the TB Division.

There have been about 104 separate patient referrals to the counselor through the year with most coming through the Admission Ward or at the time of Patient-Family Conferences. For the last month of the year, Mr. Black has held orientation and therapy group meetings on the wards. During the summer of 1967 a nurse and a social worker attended the Rutgers Summer School of Alcohol Studies and this summer, 1968, our counselor and another nurse are attending.

An interview of the year's experience with an alcoholism counselor shows a marked improvement in staff attitudes toward alcoholism. We feel there

has been a decrease in TB Division problems related to alcoholism. We seem to have fewer staff difficulties in management of alcoholism problems on the wards. We are certain of improved community relationships with such agencies as the Alcoholism Center and AA, and with the families of our patients.

We are looking forward to trying to establish a more effective system of referrals to the Alcoholism Center. We hope there can be a closer coordination of community alcoholism and TB clinics. We feel there is a need for more half-way houses to facilitate the movement of TB-alcoholism patients to the community. We hope to explore the possibility of having AA pick up our patients prior to discharge for follow-up in the community.

The only way we can be certain of the success or failure of our alcoholism-TB program in the hospital is to have follow-up reports from the Alcoholism Center and from Baltimore City Health Department TB Clinics. We are enthusiastic enough about the pilot demonstration over the first year to have asked for two alcoholism counselors for the TB Division beginning July 1, 1968. The City of Baltimore approved this request, and the positions were made available June 1, 1968.

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HEART PAGE

Jerry Salan, MD, Editor

A Service of the Heart Association of Maryland

Vectorcardiography

Spatial vectorcardiography is a three-dimensional study of the electrical forces of the heart with emphasis on the phasic relationships. The vectorcardiogram is usually recorded from the oscilloscopic image in three mutually perpendicular planes, i.e. horizontal, sagittal, and frontal projections. The oscilloscopic beam is regularly interrupted for timing purposes. The vectorcardiographic curves consist of a rapidly inscribed large QRS sE loop and more slowly inscribed and smaller T and P sE loops.

Y. C. LEE, MD
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Although the vector concept dates back to Einthoven, Fahr and de Waart, the clinical application of vectorcardiography occurred much later than the routine scalar electrocardiogram. Unlike scalar electrocardiography, which has a universally accepted lead system, there is an abundance of vectorcardiographic lead systems. There is as yet no agreement as to the acceptance of one specific vectorcardiographic system. At the present time, the Frank lead system with seven electrode positions appears to be the most frequently one employed.

It is not within the scope of this presentation to discuss the advantages and disadvantages of the various lead systems. One system may be of greater value in certain specific conditions because of the enhancement of the sagittal or horizontal components.

During the last three decades, there have been many studies comparing vectorcardiography to the routinely recorded conventional scalar electrocardiogram. There are certain advantages and disadvantages in each system, relating to the techniques of recording and to the presentation of the data. It is apparent that vectorcardiography cannot replace routine scalar electrocardiograms. Vectorcardiography has no value in the analysis of arrhythmias, and provides less readily recoverable information pertaining to the P–R and Q–T intervals, ST segment, P and T waves. The main merits of vectorcardiography are related to the ease of recording, the simple form of data presentation, its great teaching value, and to the emphasis on phasic relationship.

Vectorcardiography is a useful adjunct to electrocardiography in the diagnosis of ventricular hypertrophy, myocardial infarction, and intraventricular conduction disturbances. The spatial relationship of the QRS and T sE loops is of value in determining repolarization abnormalities which may not be apparent from the scalar records. The direction of inscription of the QRS sE loops offers potentially important information not readily available from the scalar tracing because of the emphasis in vectorcardiography on phase relationships.

When the clinical findings are compatible with an atrial septal defect, the presence of a counterclockwise direction of inscription and the superior displacement of the QRS sE loop in the frontal plane projection are highly suggestive of an ostium primum type of defect. Vectorcardiography may be useful for the diagnosis of right ventricular hypertrophy in the younger age groups when the electrocardiograms so often reveal a normal degree of right ventricular preponderance and are difficult to evaluate.

Scalar electrocardiograms may be similar, but the vectorcardiograms may be quite different in patients with rSR′ recorded over the right precordium. These rSR′ configurations recorded in the scalar electrocardiogram may be accompanied by vectorcardiographic evidence of right ventricular hypertrophy or terminal conduction delay of the right bundle branch type.

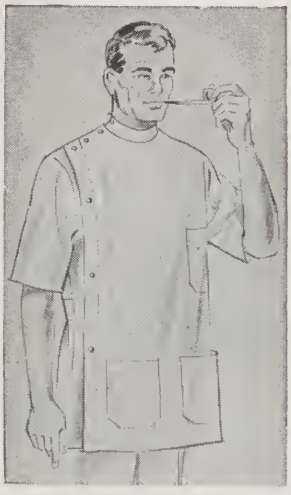
In the presence of low voltage in the limb leads, the determination of the frontal plane QRS axis may be difficult from the scalar leads and the vectorcardiogram may be helpful in such instances. Deformations of the QRS sE loop have also been reported as a characteristic finding in certain conditions. Such deformations in the QRS sE loop are usually represented as notches in the scalar leads and are difficult to interpret.

In the past, the analysis and interpretation of vectorcardiograms have been largely descriptive. Recently, more efforts have been made toward a quantitative approach. Vectorcardiography is a useful adjunct to electrocardiography when the interpretation of the scalar electrocardiogram is equivocal.

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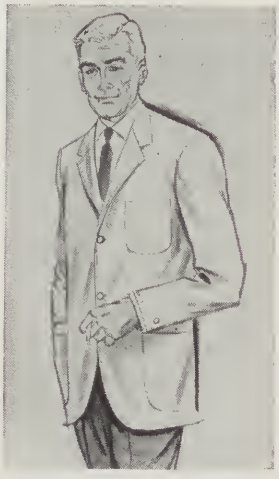
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DOUGLAS G. CARROLL, MD, EDITOR

Measurement of Performance in Rehabilitation*

"Only occasionally will a symbolization be available which, without loss of its symbolic accuracy, is also suitable (for the author's attitude toward his public), appropriate (to his referent), judicious (likely to produce the desired effects) and personal (indicative of the stability or instability of his references). The odds are very strongly against there being many symbols able to do so much. As a consequence, in most speech, some of these functions are sacrificed." [1]

ACTIVITIES OF DAILY LIVING (ADL)

The method used to score physical activity has been worked out by Mahoney and Barthel [2, 3] and is shown in Table 1. An ADL form was completed on each patient when seen initially. This form gives a score (on the basis of 100) of the patient's ability to care for the daily needs of feeding, dressing, personal toilet, wheelchair activities, ambulation and going up steps. It is also scored for incontinence.

Table 2 shows that total scores determined by two different trained observers independently had a Spearman Rank Correlation Coefficient of .939 (corrected for ties).

Table 3 shows the reliability correlation of the scoring of individual items in the ADL by two trained observers working independently.

The ADL items are specific purposeful activities, which the patient must be able to perform in order to be able to care for his own needs. Over the last 20 years, these activities of daily living items have been standardized by various workers to constitute a sample of activities needed for self-care. There are ten items (with #7 a sub item of #6, to be used only when the patient cannot walk). These items quite obviously are abstractions, directly related to the social goals of the patients (self-care). In the various items, many of the basic movements are reduplicated. Certainly there is no need to think of the various items as completely separate basic motor activities.[4, 5, 6]

These items can be treated in a number of ways.

☐ They can be used as separate items to follow the patient throughout treatment.

☐ The items may be arranged into various combinations or classes.[7] Thus there might be a class in which all patients had independence in feeding, continence, transferring, going to the toilet, dressing and bathing. Another class might include independence in all but one of these functions. Such classes can be arranged into an ordinal scale. Members of the same class will all be able to do the same activities. If patients are followed, they may progress from one class to another and thus improvement, deterioration or no change may be identified as changing with time.

☐ Another way to treat the items is to give each a numerical value and add them. If each item were given a value of 1, then a patient with a value of 10 should be completely independent, whereas a

* This is the fourth of a series of notes on "Rehabilitation of Chronic Impairments in Adults."

patient with a score of 0 would need complete nursing care. Although the inability to perform a single item might render an individual patient dependent because of some special circumstance in his home, in the great majority of patients, the higher the score, the greater the degree of independence.

☐ A fourth method of using the items is to give more value to certain items than to others, and to add them for a total score. This is the method we have used (together with method 1) to evaluate and follow our patients' degree of independence. Items 1, 2, 3, 8, 9 and 11 each have three possible scorings of 0, 5 or 10. Items 4, 5 and 7 have two possible scores. Item 10 has three possible scorings of 0, 10 or 15. (Item 7 is a special item which is used only when 10 and 11 are impossible.) Item 6 has four possible scores: 0, 5, 10, 15.

The total score has two potential uses. Patients with different scores may be placed in different classes. This system is similar to a method proposed for the measurement of severity of illness on admission to the hospital in patients with acute myocardial infarction.[8] A number of situations (first order abstractions similar to the ADL items) were sought at the bedside of patients with acute mycardial infarctions. These items were shock, arrhythmias, gallop rhythm, associated diseases and historical items. Each finding was given a numbered value in relation to its expected seriousness for prognosis for life. These item scores were then added, and the patients were placed in groups depending on the total score.

The total score taken alone has some significance in indicating a patient's degree of independence, but it is not accurate since the actual items making up the score are unknown.

The total scores were divided arbitrarily into six score groups: 0–20, 21–40, 41–60, 61–80, 81–95 and 96–100. The extra category 96–100 was included to define patients who were almost completely independent.

A comparison of similar total scores in patients with hip fracture is shown in Table 4. The homogeneity of deficient items of activity in patients with the same ADL score will vary with the diagnosis.

☐ A fifth way to use the items is to compare total scores serially in an individual patient as an estimation of whether the patient is improving or deteriorating in physical independence.

In an individual patient, serial scores give an accurate description of the patient's independence. Improvement in independence is defined as sufficient increase in the ADL score to place a patient in a higher score group. A patient was considered to have experienced no increase in independence (unchanged) if he remained in the same score group after a period of treatment. Deterioration of function was defined as a drop in ADL score to a lower group.

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TABLE 1

Definition of Scoring of Activities of Daily Living

1. Continence of Bowels

10=Patient is able to control his bowels and have no accidents. He can use a suppository or take an enema when necessary (as for spinal cord injury patients who have had bowel training).

5=Patient needs help in using a suppository or taking an enema or has occasional accidents.

2. Controlling Bladder

10=Patient is able to control his bladder day and night. Spinal cord injury patients

who wear an external device and leg bag must put them on independently, clean and empty bag, and stay dry day and night.

5=Patient has occasional accidents or cannot wait for the bed pan or get to the toilet in time or needs help with an external device.

3. *Feeding*

10=Independent. The patient can feed himself a meal from a tray or table when someone puts the food within his reach. He must put on an assistive device if this is needed, cut up the food, use salt and pepper, spread butter, etc. He must accomplish this in a reasonable time.

5=Some help is necessary (with cutting up food, etc., as listed above).

4. *Doing Personal Toilet*

5=Patient can wash hands and face, comb hair, clean teeth, and shave. He may use any kind of razor but must put in blade or plug in razor without help as well as get it from drawer or cabinet. Female patients must put on own makeup, if used, but need not braid or style hair.

5. *Bathing Self*

5=Patient may use a bath tub, a shower, or take a complete sponge bath. He must be able to do all the steps involved in whichever method is employed without another person being present.

6. *Moving from Wheelchair to Bed and Return*

15=Independent in all phases of this activity. Patient can safely approach the bed in his wheelchair, lock brakes, lift footrests, move safely to bed, lie down, come to a sitting position on the side of the bed, change the position of the wheelchair, if necessary, to transfer back into it safely, and return to the wheelchair.

10=Either some minimal help is needed in some step of this activity or the patient needs to be reminded or supervised for safety of one or more parts of this activity.

5=Patient can come to a sitting position without the help of a second person but needs to be lifted out of bed, or if he transfers with a great deal of help.

7. *Propelling a Wheelchair*

5=If a patient cannot ambulate but can propel a wheelchair independently. He must be able to go around corners, turn around, maneuver the chair to a table, bed, toilet, etc. He must be able to push a chair at least 50 yards. Do not score this item if the patient gets score for walking.

8. *Dressing and Undressing*

10=Patient is able to put on and remove and fasten all clothing, and tie shoe laces (unless it is necessary to use adaptations for this). The activity includes putting on and removing and fastening corset or braces when these are prescribed. Such special clothing as suspenders, loafer shoes, dresses that open down the front may be used when necessary.

5=Patient needs help in putting on and removing or fastening any clothing. He must do at least half the work himself. He must accomplish this in a reasonable time.

9. *Getting On and Off Toilet*

10=Patient is able to get on and off toilet, fasten and unfasten clothes, prevent soiling of clothes, and use toilet paper without help. He may use a wall bar or other stable object for support if needed. If it is necessary to use a bed pan instead of a toilet, he must be able to place it on a chair, empty it, and clean it.

5=Patient needs help because of imbalance or in handling clothes or in using toilet paper.

10. *Walking on a Level Surface*

15=Patient can walk at least 50 yards without help or supervision. He may wear braces or prostheses and use crutches, canes, or walkerette but not a rolling walker. He must be able to lock and unlock braces if used, assume the standing position and sit down, get the necessary mechanical aides into position for use, and dispose of them when he sits. (Putting on and taking off braces is scored under dressing.)

10=Patient needs help or supervision in any of the above but can walk at least 50 yards with a little help.

11. Ascending and Descending Stairs

10=Patient is able to go up and down a flight of stairs safely without help or supervision. He may and should use handrails, canes, or crutches when needed. He must be able to carry canes or crutches as he ascends or descends stairs.

5=Patient needs help with or supervision of any one of the above items.

A score of 0 is given in all of the above activities when the patient cannot meet the criteria as defined above.

TABLE 2

Correlation of Total ADL Scores on 10 Patients by Two Observers

JUDGE #1=X
JUDGE #2=Y
r_s=Spearman Rank Correlation Coefficient
(uncorrected)=.942
(Corrected for ties)=.939

SUBJECTS	*X*	*Y*
1	100	100
2	50	30
3	80	65
4	100	95
5	55	45
6	100	100
7	70	80
8	5	5
9	100	100
10	100	95
TOTAL:	760	715

TABLE 3

Correlation Between Individual Items on ADL Scale of Two Observers on 10 Patients.

(92 item scores were identical; 15 were one degree off—5 points; two items were two degrees off—10 points; one item was three degrees off—15 points)

ADL ITEMS	Individual Scores given by Judge A on 10 Patients										Individual Scores given by Judge B on 10 Patients									
1	10	10	10	10	0	10	10	0	10	10	10	10	10	10	0	10	10	0	10	10
2	10	10	0	10	0	10	0	0	10	10	10	10	10	10	0	10	10	0	10	10
3	10	10	10	10	5	10	10	5	10	10	10	5	10	10	10	10	10	5	10	10
4	5	0	5	5	5	5	0	0	5	5	5	0	0	5	0	5	5	0	5	5
5	5	0	0	5	0	5	0	0	5	5	5	0	0	5	0	5	5	0	10	5
6	15	5	15	15	10	15	15	0	15	15	15	0	15	15	10	15	10	0	15	15
7	0	5	5	0	5	0	5	0	0	0	0	5	5	0	5	0	5	0	0	0
8	10	5	5	10	5	10	5	0	10	10	10	0	5	10	5	10	10	0	10	10
9	10	5	10	10	5	10	5	0	10	10	10	0	10	10	5	10	5	0	10	10
10	15	0	15	15	15	15	15	0	15	15	15	0	0	15	10	15	10	0	15	15
11	10	0	5	10	5	10	5	0	10	10	10	0	0	5	0	10	0	0	10	5
Total Score																				
	100	**50**	**80**	**100**	**55**	**100**	**70**	**5**	**100**	**100**	**100**	**30**	**65**	**95**	**45**	**100**	**80**	**5**	**100**	**95**

WILLIAM J. PEEPLES, MD, MPH, COMMISSIONER

Maryland State department of health

HIGHLIGHTS

Mandatory Laboratory Reporting Now in Effect

Mandatory reporting to the Department of positive laboratory findings in examinations for syphilis, gonorrhea, and tuberculosis, enacted by the 1968 General Assembly, became effective July 1. Clinical laboratory directors have received instructions and report forms, which must include the name and address of the laboratory, patient identification information, the name and address of the physician submitting the specimen, and the type and result of the examination made.

Laboratories are encouraged to provide as much identifying information as possible, to simplify epidemiologic follow-up by the Division of Communicable Diseases. However, no patient or his potential contacts will be approached without the consent of his attending physician, when there is an attending physician. The reports are confidential and will not be open to public inspection.

Yellow Fever Vaccination Stations Established

The Division of Communicable Diseases has requested and received permission from Foreign Quarantine Service of NCDC to establish yellow fever vaccination stations at Hagerstown, Cheverly, and Salisbury (Washington, Prince George's and Wicomico County Health Departments). Yellow fever vaccination, recommended for travelers to South America or Central Africa, has formerly been available only at U. S. Public Health Hospitals in Baltimore and Washington. The one-shot immunization is effective for ten years. It must be recorded on the International Vaccination Certificate and duly stamped.

Cutbacks in the Medical Assistance Program

The cutbacks ordered by the Governor in the Medical Assistance Program, effective July 1, did *not* affect the indigent but did make ineligible a certain number of those previously certified as *medically* indigent.

Those who remain eligible as medically indigent are required to share a portion of their medical expenses as follows:

☐ Hospital inpatients are required to pay the first $40 for each admission, and coverage is limited to 21 days for each admission.

☐ Patients cared for in a hospital outpatient department or emergency room are expected to pay the hospital $1 per visit.

☐ Each patient is expected to pay his physician $1 for each home or office visit. (This requirement does not apply to hospital inpatients or patients in nursing homes.)

☐ Patients are expected to pay 70 cents to the pharmacist for each prescription or drug order filled. If the retail price of an over-the-counter product is less than 70 cents, only the retail price is to be paid.

☐ Each patient is expected to pay his dentist 50 cents per visit, regardless of services performed, except for services requiring pre-authorization. In these cases, the patient is expected to pay 10% of the allowable fee, based on the fiscal year 1966–67 Health Department fee schedule.

The medically indigent are identified by the addition of the letter "P" following the certification number on the Medical Assistance card. The indigent are identified by the letter "N" following the number. Letters were sent to all providers of service, notifying them of these changes, and instructing them not to honor the present buff-colored cards after June 30. Letters were also sent

to recipients affected by the new policy, explaining the co-payment features; persons removed from the program were similarly notified.

Division of Nursing Conducts Quarterly Regional Meetings

The quarterly regional meetings conducted in July by the Division of Nursing covered the following topics: (1) An Operational Plan for Health Mobilization, State of Maryland, (2) Family Involvement—Before, During, and After Hospitalization, (3) Policy Series for Tuberculin Testing and X-ray of Public Health Nurses, and (4) Policies Regarding Use of Health Education Materials. The regions are designated as follows:

Region I—the nine counties of the Eastern Shore

Region II—the four western counties

Region III—the four southern counties

Region IV—the two metropolitan Washington area counties

Region V—Baltimore City and four Baltimore area counties.

City-State Training Venture Concludes

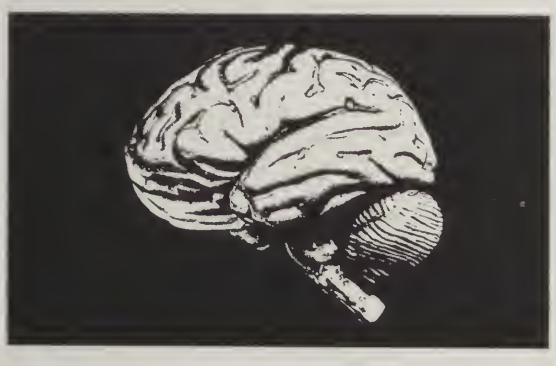
The first in-service training for sanitarians cosponsored by the Environmental Health Service of the Baltimore City and State Health Departments recently concluded a successful five weeks. The full-time, college level course was attended by eight sanitarians from Baltimore City, two from Anne Arundel County, and one employee of the Washington County Health Department. Deriving mutual benefits in meeting training needs of both city and State, the two agencies plan to continue the cooperative arrangement.

Dr. Garber Finishes Tour of Duty

Howard J. Garber, MD, U. S. Public Health Service Epidemiologic Intelligence Officer, has completed his two-year tour of duty with the Division of Communicable Diseases, and will leave the Department to obtain his MPH at The Johns Hopkins School of Hygiene and Public Health. Following this, he plans to return to the Department as an employee of the State.

Dr. Garber has concentrated his efforts in the past two years on the eradication of measles in Maryland, and is probably better known to school children throughout the State than any other member of the Department. He has also performed valuable service in carrying out epidemiologic investigations of vaccine effectiveness and various epidemics.





JAMES E. CARSON, MD, ACTING COMMISSIONER
KURT GORWITZ, ScD, STATISTICS DIRECTOR

Maryland State department of mental hygiene

The National Scene

Expenditures in the United States in 1967 for the maintenance of patients in state and county operated mental hospitals exceeded 1.4 billion dollars.* This represented a record increase of 115 million dollars, or 8.8%, over the previous year's comparable figure. Total costs have nearly doubled since 1957 and are now more than one-third higher than they were five years ago.

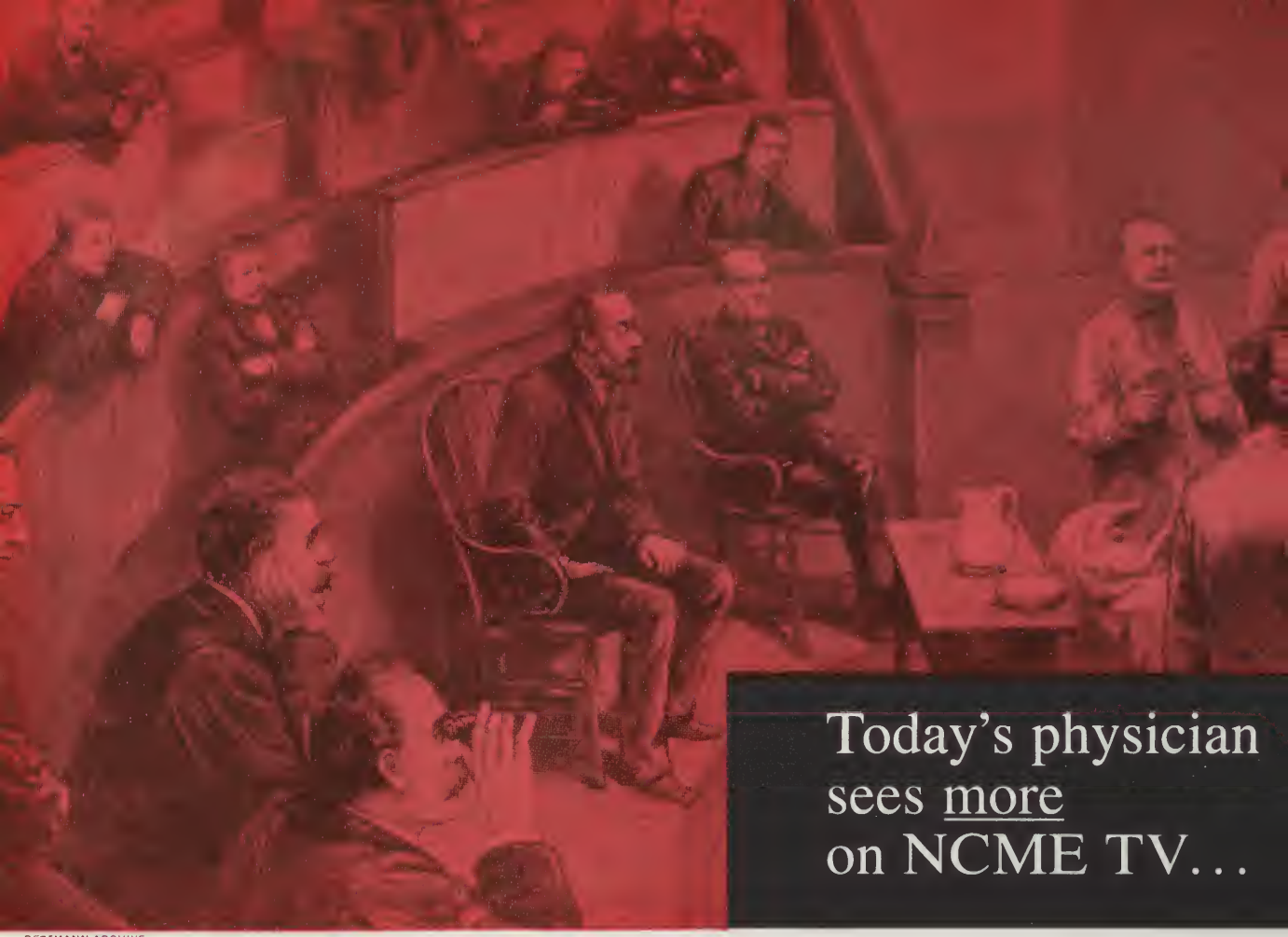
Hospital expenditures have continued to go up although the average number of patients in these facilities has decreased steadily. Nationally, a decline in the patient population of 20.2% (from 549,330 to 438,587) occurred between 1957 and 1967. As a result, the average cost of caring for one patient for one day rose from $3.65 to $8.84 during this ten-year period. Maryland, with a reported figure of $9.04, continued to rank approximately near the center, between the high of $32.37 for Alaska and the low of $3.99 for Mississippi. Despite patient improvements, these figures indicate a widespread continuing lag behind comparable cost data for general hospitals as well as for federal (V.A.) psychiatric hospitals.

Fiscal Year	Average Size of Patient Population	Net Live Releases	Total Expenditures	Expenditures Per Net Release
1957	549,330	150,413	$ 731,875,462	$4,865.77
1962	519,742	230,158	1,033,567,884	4,490.68
1966	460,910	311,827	1,300,622,459	4,170.97
1967	438,587	335,737	1,415,480,302	4,216.03
Percent Change (1967 vs. 1957)	**—20.2**	**+123.2**	**+93.4**	**—13.4**

While these data reflect rising personnel-patient ratios, the current emphasis on psychopharmacology and other innovations in treatment services, they are primarily related to the rapidly increasing patient turnover resulting from shortened periods of hospitalization for new admissions and the transfer of many long-term patients to nursing homes. As indicated in the above table, releases have more than doubled between 1957 and 1967. In fact, this rise has been so large that the average expenditure required to produce one net release is now 13% less than it was ten years ago.

If present trends continue, the average daily cost per patient must be expected to rise 10% or more per year even though the average total cost of each episode declines further. The only alternative to continuing, uninterrupted increases in state psychiatric hospital expenditures is to reduce drastically the size of patient populations by 1) providing community programs as an alternative to hospitalization, 2) further decreasing the average period of hospitalization, 3) transferring chronic, custodial patients to nursing home type facilities and 4) developing and expanding aftercare services for released patients. These can be accomplished through closely coordinated and centrally directed programs offering a variety of community and hospital services to the mentally disturbed, and through the implementation of current and new concepts for the prevention of mental illnesses.

* Office of Biometrics, National Institute of Mental Health, Series MHB–H12, Provisional Patient Movement And Administrative Data—State And County Mental Hospitals—United States—July 1, 1966–June 30, 1967.



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A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to NCME, 342 Madison Avenue New York, N.Y. 10017

ROBERT E. FARBER, MD, MPH, COMMISSIONER

Baltimore City health department

Family Planning Clinics

A new evening Family Planning Clinic has been opened in the Western Health District Building, 700 W. Lombard Street, by the City Health Department's Maternity Center. The evening clinic meets the demand for family planning services by women who are unable to attend the regular Family Planning Clinic in this area during the day. The new clinic is held Tuesdays at 5:30 P.M. and is by appointment only, telephone 837–2710.

Kathleen A. Swallow, MD, is Director of the City Health Department's Maternity and Infant Care Project 501 which sponsors the family planning clinics. Physicians may obtain additional information on the City's Family Planning Clinics by calling the Baltimore Maternity Center, 211 W. Lombard Street, telephone 752–7282.

Sixteen family planning clinic sessions are now held throughout the city as follows:

DRUID HEALTH DISTRICT
1515 W. North Avenue 728–0600
Mon., Tues., Thurs., Fri.—8:30 A.M.
Tuesday—7:00 P.M. by appointment

SOUTHERN HEALTH DISTRICT
1211 Wall Street 727–3471
Wednesday—8:30 A.M.

CHERRY HILL
2700 Spelman Road 355–3595
Monday—8:30 A.M.

SOUTHEASTERN HEALTH DISTRICT
1817 E. Baltimore Street 342–5200
Tues.—12:30 P.M., Thurs.—9:00 A.M.

WESTERN HEALTH DISTRICT
700 W. Lombard Street 837–2710
Tuesday & Thursday—12:30 P.M.
Tuesday—5:30 P.M. by appointment

EASTERN HEALTH DISTRICT
620 N. Caroline Street 732–7110
Mon., Wed., Thurs., Fri.—8:30 A.M.

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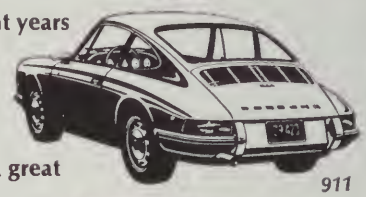
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HARRISBURG, PA. 17102
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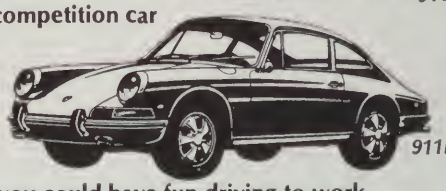
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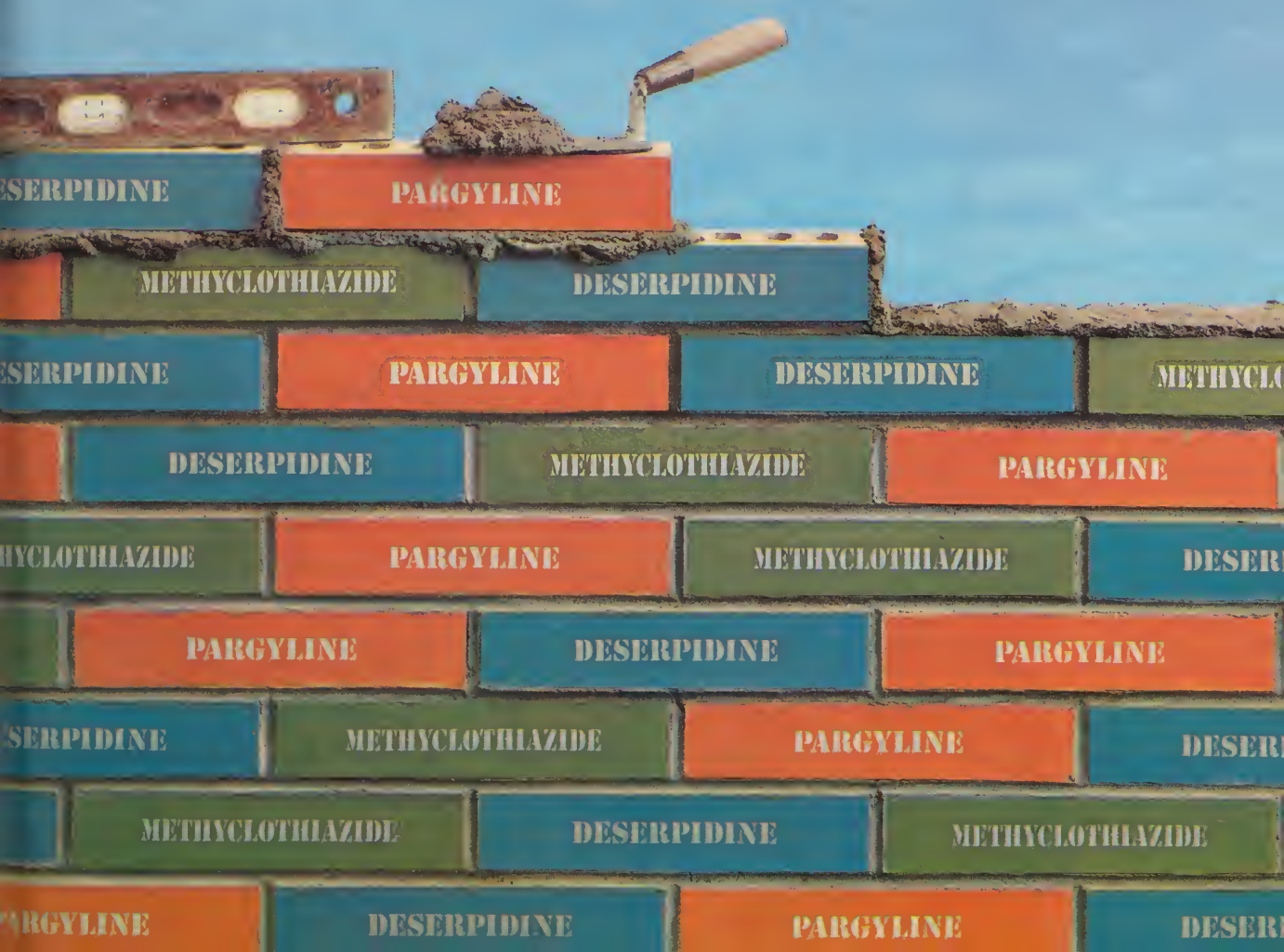
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Enduron: (methyclothiazide) A basic building block for mild hypertensives



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The therapeutic action is smooth, and persists for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

ENDURON®

METHYCLOTHIAZIDE

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

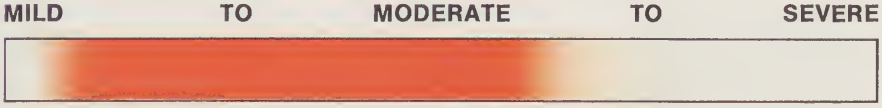
Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

Once a day, every day

ENDURONYL®

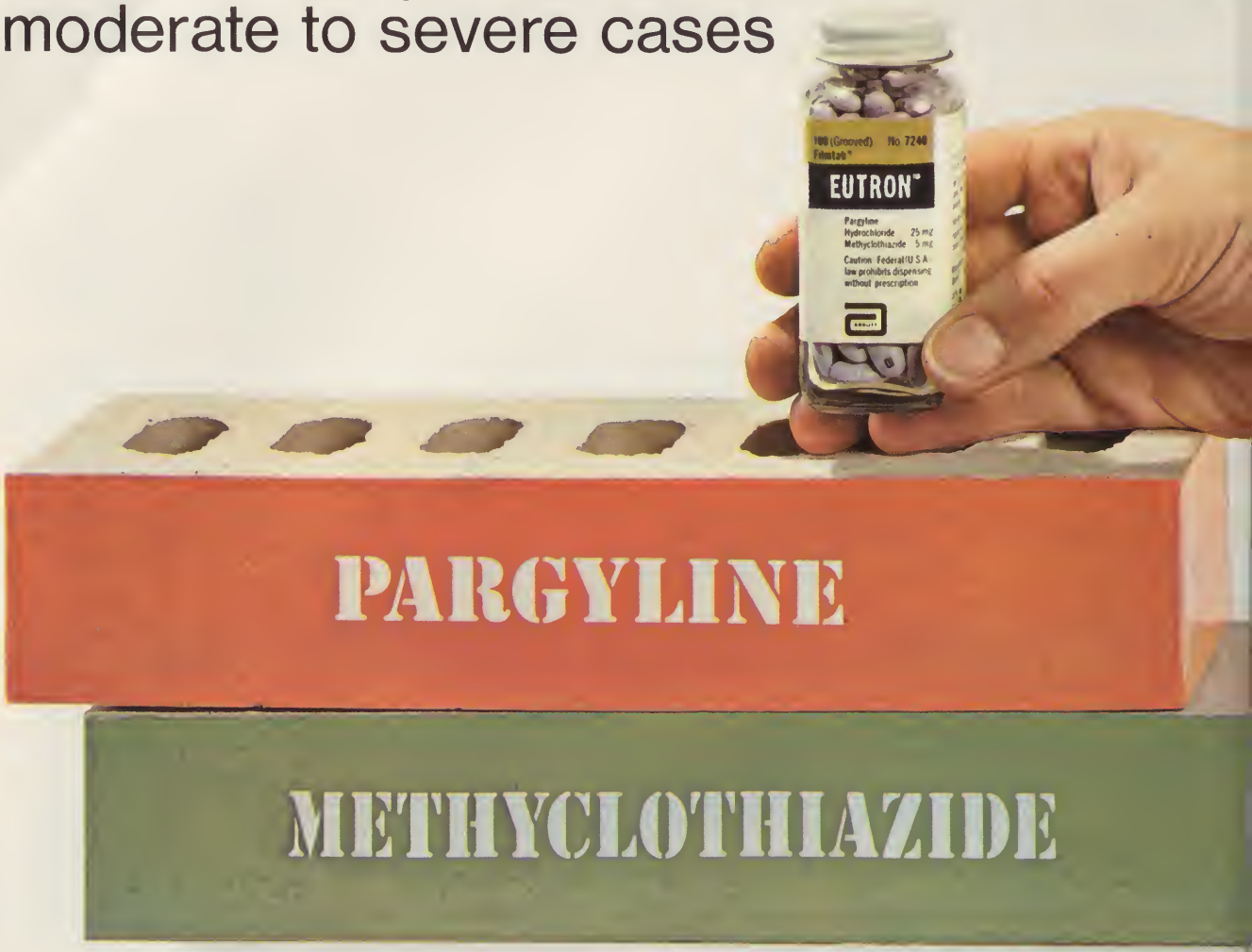
METHYCLOTHIAZIDE 5 mg. with DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.



See Brief Summary on final page of advertisement

801094

Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

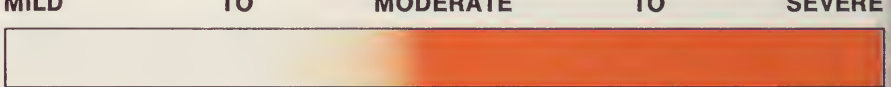
Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

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EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

801094

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804439R

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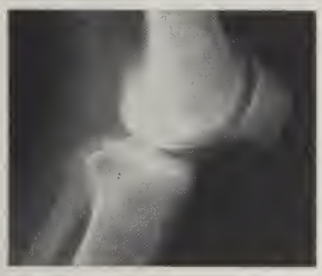
Tandearil® in Osteoarthritis
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.
Warning: Tandearil is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.
Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.
Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reacti-

"Pain Break" for an osteoarthritic.

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Of course, Tandearil is not for every osteoarthritic. Select your patients carefully and follow them in line with the Contraindications, Precautions, Warning, and Adverse Reactions listed below.

But for many aspirin-stubborn osteoarthritics, let Tandearil ease the unwelcome pain breaks of osteoarthritis.

Tandearil®
oxyphenbutazone

vate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis) or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity, angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily. In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and other factors influencing drug response. Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

For complete details, please see full Prescribing Information.

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PAUL F. GUERIN, MD, CHAIRMAN
Library and History Committee
ELIZABETH SANFORD
Librarian

library

Summer, 1968

After a week in Los Angeles attending the Special Libraries Association Convention, followed by another week of Medical Library Association meetings in Denver, this librarian found it difficult, but necessary, to settle down to the daily routine of our own library.

The new summer schedule of projects, jobs, and personnel makes for an ever changing show of faces and personalities. With summer help the library will benefit by turning attention to several neglected areas, such as the picture file, up-dating the periodical shelf list, and periodical holdings lists.

* * * *

Conference Echoes

Special Libraries Association

Los Angeles, California, June 1-7, 1968

With 1,740 librarians registered for the Special Libraries Association conference and meetings scheduled proportionately, it was a race to see how many meetings relative to our particular type of library we could fit in.

Following several preliminary meetings, such as the Forum on Education and First Conference Attendees' reception, the plenary session met at the Los Angeles Music Center, after a champagne buffet on Sunday evening.

The initial meeting of the Biological Sciences Division featured Robert L. Metcalf, PhD, speaking on the *Challenges of Applied Biology*. The Advisory Council meeting, which is always open to members, proved interesting, but not as animated in discussion as last year. The main action was a vote to increase individual dues to $30.00 per year.

Many sessions on automation and information retrieval for industrial, scientific and other special libraries were scheduled. The next major meeting of Biological Sciences Division occurred at the U C L A Center for Health Sciences, where a panel presentation by the *U C L A Brain Information Service* was followed by a tour of the Biomedical Library, including their new Rare Book Room.

Wednesday evening being free, several Baltimore librarians decided on an 'after dark' tour of the city only to be greeted on our return by the news of the shooting of Senator Robert F. Kennedy. That night was a wakeful one for all the hotel guests who heard and saw the television broadcasts as the tragedy happened. And what a shattering experience to look out your hotel window and see a huge torch aflame near the hospital where he was first taken!

Despite all the emotionally upset conditions the meetings progressed as planned, with a visit to the Los Angeles County Medical Society Library, graciously guided by John Connor, the librarian. It is an interesting building with an aura of

the old and new combined. As with our own library Los Angeles County has a fine rare book collection, but with the advantage of separate housing. Their membership for the one county exceeds our state membership, naturally, and for that reason assures a concentration of borrowers.

The awards banquet was beautiful with piñatas hanging from the ceiling and on tables for souvenirs. The Baltimore chapter now has one for a mascot.

* * * *

Medical Library Association

Denver, Colorado, June 9–14, 1968

Arriving in Denver Sunday afternoon in time to register, unpack and have dinner in the venerable Brown Palace, we were greeted by a table full of Baltimore librarians. At least a dozen were in attendance.

Monday included a trip to the University of Denver Library, and the University of Colorado Medical Center where a Medlars regional library is operating. In the evening the session on library architecture involved a presentation of the planning and programming preceding the building of the William S. Middleton Medical Library, University of Wisconsin, Madison, by the librarian, Helen Crawford. A critique by Sam W. Hitt, University of Connecticut, followed, with audience participation. Mr. Robert Walkington prefaced this presentation by reviewing the National Library of Medicine's accomplishments and current status regarding construction grants. This program is becoming routine with MLA and is very helpful for librarians planning new buildings in the future.

The general sessions revolved around the subject of regional library networks. At the Medical Society Libraries Group dinner discussions of Harvard's Countway Library, by Charles Colby; the Academy of Medicine of New Jersey, by Jacqueline Picciano; and College of Physicians of Philadelphia, by Elliot Morse, dealt mainly with the results of mergers in their own libraries. The chairmanship of the next Medical Societies Group, which will meet in Louisville, probably in October, 1969, seems to have fallen to the lot of this librarian. There had been some discussion as to whether to arrange a meeting of MLA in 1969 or omit it since there will be the Third International Congress on Librarianship in Amsterdam, May 5–9, 1969.

One enjoyable combined tour-library visit took us to the Library of the National Center for Atmospheric Research, Boulder, Colorado and on to a ranch for a "chuck-wagon supper."

The business meeting and inaugural address of Mrs. Jacqueline Felter preceded the contributed papers sessions Thursday morning and an afternoon session on current cataloging problems ended the formal program of the convention, except for the banquet and awards. Miss Gertrude Annan received the Marcia C. Noyes award as outstanding medical librarian for the year and three scholarships were granted to new library school recruits.

* * * *

Help!

The first phone call I received in L.A. was Mr. Sargeant telling me the building here had been burglarized that week-end and they feared some rare books may have disappeared, since the lock on our safe had been pried off! So, we want to warn everyone that should they spot some rare looking tomes with the Medical and Chirurgical Faculty of Maryland stamp on them, or identification written in, please let us know.

New Accessions

BOOKS

(Arranged by author and title)

RD
84
A2
1967

Adriani, John
Labat's regional anesthesia; techniques and clinical applications. 3d ed. Philadelphia, Saunders, 1967.

Ref.
Z
6660
A5
1967

American Medical Association. Archive Library Department.
Index to medical socioeconomics literature. v. 6, Chicago. American Medical Association, 1967.

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Z
6660
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American Medical Association
AMA News Index. v. 10. Chicago, American Medical Association, 1967.

RG
600
B3
1968

Barnes, Allan C.
Intra-uterine development. Philadelphia, Lea & Febiger. 1968.

RC
537
B4
1967

Beck, Aaron T.
Depression: clinical, experimental, and theoretical aspects. New York, Hoeber Medical Division, Harper & Row, 1967.

RE
731
B5
1943

Bielschowsky, Alfred
Lectures on Motor Anomalies with a foreword by Walter B. Lancaster. Hanover, Dartmouth College, 1943.

R
856
C3
1966

Carlisle, Norman V.
Marvels of medical engineering. New York, Sterling Publishing Company, 1966.

LB
1050.5
C7
1968

Crosby, Robert M. N.
The waysiders; a new approach to reading and the dyslexic reader. New York, Delacorte Press, 1968.

R
489
.L75
D8
1924

Dukes, Cuthbert Esquire
Lord Lister. London, L. Parsons, Boston, U.S.A., Small Maynard and Company, 1924.

QP
801
.H7
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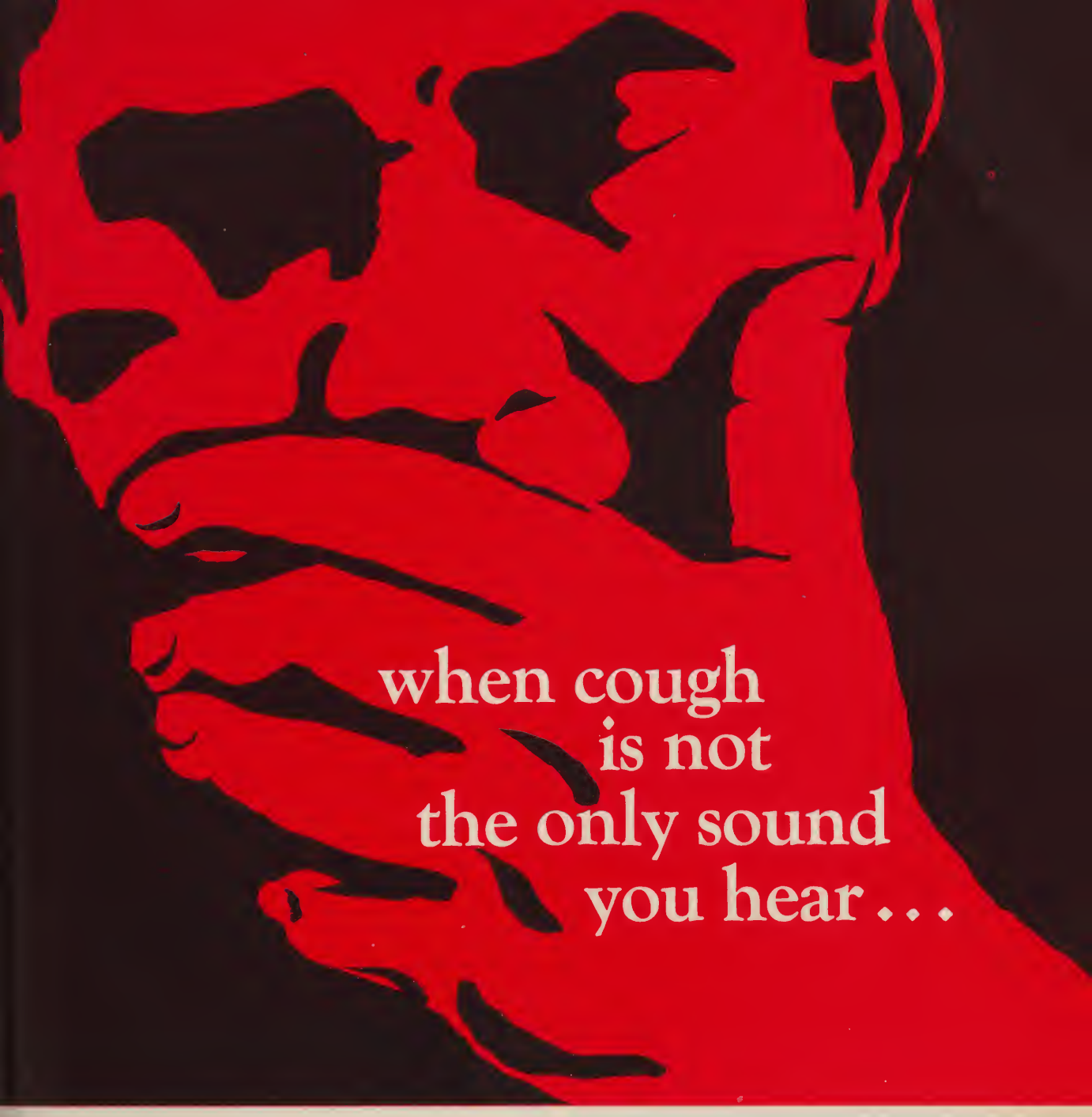
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Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

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New Arthritis Prevalence Figures Revealed

New survey figures which put the number of people in the U. S. suffering from some form of arthritis at 16,800,000 are revealed in the 20th Anniversary Annual Report (1967) of The Arthritis Foundation.

This is an increase of more than 3,000,000 over previous estimates of the country's arthritis population. Since the total population of the country is more than 200,000,000, it means that one in 11 people have arthritis. The old figure was one in 16.

The Foundation report lists statistics contrasting the size of the nation's arthritis problem with the amount of money being used to do something about it.

"The latest figures attest vividly," the report comments, "to an incongruous disparity . . . a disease with a staggering impact on society being assigned by that society an absurdly low priority for attention."

Last year, 24% of the voluntary health organization's expenditures went to research, 23% to professional health education and training, and 21.6% went to patient and community services. In 1967, the agency collected $7,072,604 to support its projects.

The new arthritis prevalence estimate resulted from a National Health Interview Survey conducted in 1966–67 by the U. S. Public Health Service's National Center for Health Statistics.

Among other statistics cited in the report are included: An estimated 3,400,000 arthritis victims are disabled—limited in their usual activities—at any one time; including annual wage losses and medical care costs due to arthritis, the total annual cost to the national economy is estimated at more than 3.5 billion dollars; the total 1968 national investment in research and training for preventing arthritis is estimated at $15,000,000



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CONTRAINDICATIONS: Sensitivity to Cantil® (mepenzolate bromide), glaucoma, G.I. or G.U. obstruction, toxic megacolon. WARNINGS: Possibility of adverse reactions in advanced severe ulcerative colitis and atypical agitated reactions to phenobarbital in the elderly (Cantil with Phenobarbital). PRECAUTIONS: Cantil is of adjunctive use only; treatment of the underlying condition is indicated, be it organic or functional. Observe caution in conditions known to be incompatible with atropine-like drugs, e.g., open-angle glaucoma or prostatic hypertrophy. ADVERSE EFFECTS: Dry mouth; blurred vision; constipation; nausea; vomiting; bloating; dizziness; urinary retention. All are anticholinergic effects and usually tolerable. Habituation and idiosyncratic reactions to phenobarbital (Cantil with Phenobarbital) are possible, as is generalized rash. DOSAGE: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required. HOW SUPPLIED: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

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"Marihuana and Society"

The June 24, 1968 issue of *JAMA* contained a two-page article entitled, "Marihuana and Society," produced through the combined efforts of the AMA's Council on Mental Health, its Committee on Alcoholism and Drug Dependence, and the Committee on Problems of Drug Dependence of the National Research Council, National Academy of Sciences.

The groups concluded that marihuana (cannabis) is a dangerous drug, that its legalization would create a serious abuse problem in the United States and that penalties for violations of the marihuana laws are often harsh and unrealistic. In closing, it states: "An informed citizenry, in the final analysis, is the most effective deterrent of all."

A reprint of this timely joint statement may be obtained—without cost—from the Council on Mental Health, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.



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The AMA's Committee on Aging: It Strives to Prolong Life – and Living

"Out of all the human beings who have reached the age of 65 since the dawn of recorded history, 25% are alive today."

That statement strikes with dramatic impact the first time one hears it. And when one hears or reads it anew, he can't help but be piqued as he further ponders the significance of the remark.

People are living longer and they are living better, but, unfortunately, many of the nation's older citizens are not living anywhere near their optimum for the simple reason that society has not yet been able to adjust to this phenomenon of the 20th century.

Today 20-million Americans—approximately one of every ten—is 65 or older. Their situation is misunderstood by many because of the prevailing "rocking chair" or "over-the-hill" philosophy associated with the older members of society.

While those in the medical profession have a clearer understanding and greater appreciation of the needs of older citizens, they, too, reflected this kind of thinking, to a degree, when, in 1955, the AMA, recognizing the need to more fully understand the already existing and projected needs of the rapidly rising "over 65" population and potential medical solutions established a Committee on Geriatrics.

This committee was in its embryonic stages when members were confronted with the realization that its focus of concern was not non-existent "diseases of aging," but the health of all older persons, sick or well.

Rather than talk itself out of existence, however, the committee felt that one of the first orders of business was to recommend that its name be changed to the Committee on Aging. It is one of

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six committees of the Council on Medical Service.

It then established three major goals—promotion of positive health and meaningful living among the majority of older persons who were well; encouraging long-range preventive efforts for the smaller segment of this group who were frail or fragile; and attaining the best possible health care and maximum restoration for those who were ill.

The philosophy of the committee, since its inception, has been that one ages not because of the mere passage of time, but because of what happens *in* time, as opposed to another view that aging is irreversible because cells are "programmed" for so many cell divisions.

Although the thrust of the committee initially was intended to be strictly medical, the committee felt that an all-encompassing view was imperative since social, psychological and other environmental factors were inherently involved.

So members of the committee have found themselves involved with such non-medical matters as housing, retirement, family life and economics—all of which bear intimately on the health of older people—in their quest to avert and alleviate problems of older citizens.

In this quest it has helped marshall many forces to foster broader understanding of problems and ferret out realistic solutions. Through its efforts state and county medical society committees have been established to effectively help conduct medicine's positive health program for older people at their levels and join with other forces in carrying out needed programs.

The nine-member committee and its staff have worked with a number of other national organizations, including the American Association of Retired Persons, which numbers more than a million members who are keenly aware of problems and needs. To stimulate cooperation between medicine and other concerned parties, at state and local levels, the AMA has held nearly 20 regional conferences.

Among the major areas of the committee's interest is the subject of mandatory retirement. Its view that "compulsory retirement is a waste of human resources that this nation can ill afford . . . it contributes measurably to ill health resulting from lack of work, exercise and responsibility," has been aired widely.

The committee's efforts also have encouraged an increasing number of physicians to follow its outline for a periodic health appraisal in examining older patients. This appraisal, in addition to being a complete medical and personal history by systems, also includes a mental and emotional evaluation, dietary history, history of physical exercise and recreation and also a social chronology as a parallel to present illness, thus illuminating any psychosomatic relationships which may exist, and to correct certain "borderline" tendencies that may point to potential future trouble.

More recently the committee has made an extensive study of the merits of automated multiphasic screening programs which, in its judgment, can be potentially quite beneficial in long-range care, providing that such programs are subject to continuing evaluation and refinement.

The committee now is studying the plight of older citizens whose automotive insurance frequently has been arbitrarily cancelled merely because they have attained a certain age.

The committee hopes to further develop medical standards of driving competence in older individuals and to encourage physicians to apply such standards for their older patients, thus influencing insurance companies to recognize such standards in formulating underwriting requirements. Currently, at least seven states now have programs of medical evaluation of drivers and license applicants which are not keyed to chronological age.

You will be interested in the following Committee on Aging publications offered to physicians and other concerned parties:

"How Younger and Older Adults Can Improve and Maintain Their Health"

"Suggested Outline for a Periodic Health Appraisal"

"The Chronic Illness Newsletter" (bimonthly)

"More Life for Your Years" (monthly fact sheet)

Studies, Proceedings of institutes and other materials on home care programs

"Suggested Guides for Medical Society Committees on Aging"

"A New Concept of Aging"

"Health Promotion for Adults"

"Retirement, A Medical Philosophy and Approach"

"Needs of the Long-Term Patient"

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In addition to its primary indications for duodenal and gastric ulcer, Robinul Forte (glycopyrrolate) is indicated for other G-I conditions that may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

Contraindications: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

Precautions: Administer with caution in the presence of incipient glaucoma.

Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

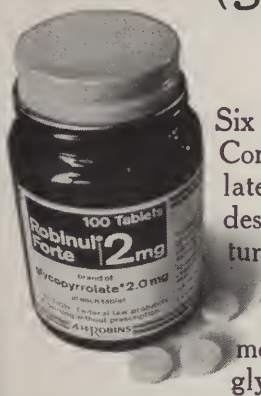
Dosage: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day; in the a.m., early p.m., and at bedtime. See product literature for full prescribing information.

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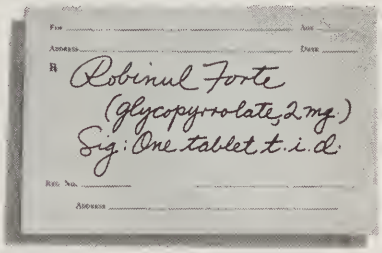
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The summation is an important part of every case. You'll find ours on the preceding page, Doctor.

Federal Medical-Health Appropriations Report

The AMA Legislative Department has recently issued a 57-page report giving details of the Federal Medical-Health Appropriations for Fiscal 1968 (July 1, 1967 to June 30, 1968). This is a valuable reference document. It gives comparative 1967 and 1968 appropriations for the various federal agencies which are active in the health field.

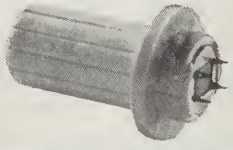
In spite of this supposedly being a year of economy, federal expenditures for health have actually increased by nearly $2.5 M. Although approximately 70% of the increase is attributable to the Medicare Program, it is apparent that increases in health expenditures have occurred in almost every federal agency. Decreases in appropriations affect only a few agencies and are generally small. In many instances, funds for construction appear to have been affected, but this is by no means always the case.

Single copies are available from the Legislative Department, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

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"Chemical Mace" May Have Serious Lasting Effects

The design of "Chemical Mace" (a mixture of tear gas and solvents) for use against individuals, together with the ability of the item to deliver an irritating substance to a localized tissue area and maintain the activity of the irritant at this spot for a period of time, clearly increases the possibility of more than transient effects to the exposed individual unless treatment is prompt.

In a statement issued in the spring, William H. Stewart, MD, then Surgeon General of the United States Public Health Service, recommended that "law-enforcement officials be advised to see that subjects controlled by the use of agents of this type be treated promptly and specifically . . . manufacturers of products of this type should stress the importance of prompt and individual treatment."

Ordinarily, flushing the areas of the body exposed to Mace with water would constitute adequate treatment. If the exposure has been severe, gentle but copious flushing of the conjunctiva, a fluorescein examination, and anti-inflammatory drops may be beneficial. Salves, creams or ointments should *not* be applied to skin until the chloroacetophenone has dissipated since they may retard its sublimination and promote local irritation.

This treatment procedure also should be followed by the police officer or any other person who may have been exposed to the substance during its period of use. In fact, absorption in the clothing of the kerosene-like solvent which is relatively non-volatile of itself can prolong the local action of chloroacetophenone and should be considered as a condition requiring treatment.

The product trademarked as "Chemical Mace" is manufactured by General Ordnance Equipment Corporation in Pittsburgh. There are, however, similar formulations on the market that are produced by other firms.

The product is essentially a pressurized can containing about 30 ml or more of a solution of chloroacetophenone in a mixed solvent consisting of 1, 1, 2,–trichloro–1, 2, 2–trifluoroethane (approximately 70–80%), 1, 1, 1, trichloroethane (approximately 5%) and a mixture of hydrocarbons resembling kerosene (approximately 4%). The concentration of chloroacetophenone in the product is stated on the label to be 0.9%. Analyses of sample items in several laboratories have indicated that the concentration may be slightly higher than this (approximately 1.2%). The major solvent belongs to the class of fluoro-hydrocarbons. The function of the trichloroethene is unknown.

The mixture is intended to be expelled as a stream rather than as a cloud, to give an effective concentration of the active ingredient at a localized point on the target.

The available evidence regarding the effects of this product on man is not complete and does not permit the drawing of final conclusions at this time. In one series of experiments on the effects of the product on human skin, it was found that exposure of voluntary human subjects to skin application of the liquid in the item produced significant skin irritation but no permanent aftereffects, and there were no signs of systemic toxicity.

A number of studies have been made regarding the effect of the item on the eyes and skin of animals. Direct addition of small amounts of chloroacetophenone-solvent mixture to the eyes of rabbits in FDA laboratories produced eye irritation whose duration and severity depended upon

the dose administered. However, the irritation disappeared with time. Other investigators have reported similar effects on monkeys. It is generally agreed that if animals are exposed to the liquid stream or spray of Mace under the expected conditions of use, the degree of eye irritation is less than that which is noted when the eyes are treated directly with the active liquid. A few studies on dogs on the possible irritant effects of liquid droplets deposited in the trachea by inhalation, have led to inconsistent findings.

There is limited information with regard to the treatment of individuals controlled by this product. The effects of tear gas disseminated in the conventional manner, as a smoke or cloud, are well-known. The use of "Chemical Mace" is different because of the localized nature of toxic agent application together with the presence of the other ingredients.

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Papers Sought for Symposium on Laboratory Animals

Scientists interested in presenting papers before an international symposium on "Defining the Laboratory Animal in the Search for Health" are invited to submit abstracts promptly to Dr. William I. Gay, Chairman of the Program Committee. The meeting will be held in Washington, April 8-11, 1969.

In a second call for papers, Dr. Gay stressed that the selection of papers for the program will be based entirely on abstracts submitted in advance. Tentative deadline for submission of abstracts is September 1, 1968.

The symposium is the fourth to be sponsored by the International Committee on Laboratory Animals and the first to be held in the United States. Co-sponsor is the Institute of Laboratory Animal Resources (ILAR) of the National Research Council.

Abstracts for the conference should be forwarded to Dr. Gay, who is Chief of the Research Grants Branch, National Institute of General Medical Sciences, National Institutes of Health, Bethesda, Maryland 20014. Abstracts should be no longer than a single 8½" x 11" page and must include the author's name and address. Candidate abstracts will be reviewed by scientists from six nations. About 30 papers, each 30 to 40 minutes in duration, will be presented at the four-day meeting.

Advance registration forms were inserted in the April issue of *ILAR News* and are also available from the ILAR office, National Research Council, 2101 Constitution Avenue, N.W., Washington, D.C. 20418.





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New AMA Pamphlet:

The Illness Called Alcoholism

Intensive study by the American Medical Association's Committee on Alcoholism and Drug Dependence of the Council on Mental Health has resulted in the publication of "The Illness Called Alcoholism."

This 16-page brochure, developed for the benefit of the laity, defines alcoholism and delves into its causes, effects, identification and treatability. It stresses that alcoholics *can* be treated successfully and that they are not to be considered "hopeless cases."

What role can a responsible citizen play in the alleviation of this problem of mounting concern? Though not an easy task, one method suggested is to persuade a suspected alcoholic to see his physician. Attempts to conceal drinking and refusal by an individual to admit that he drinks excessively are just two of the numerous symptoms listed to aid in the detection of possible alcoholism.

A complimentary review copy of this new pamphlet, which may be requested by the code number OP–192, is available from the AMA Department of Health Education, 535 North Dearborn Street, Chicago, Illinois 60610. Quantity prices are as follows: 1–49 copies, 20¢ each; 50–99, 18¢ each; 100–499, 16¢ each; 500–999, 14¢ each; 1,000 or more, 12¢ each.

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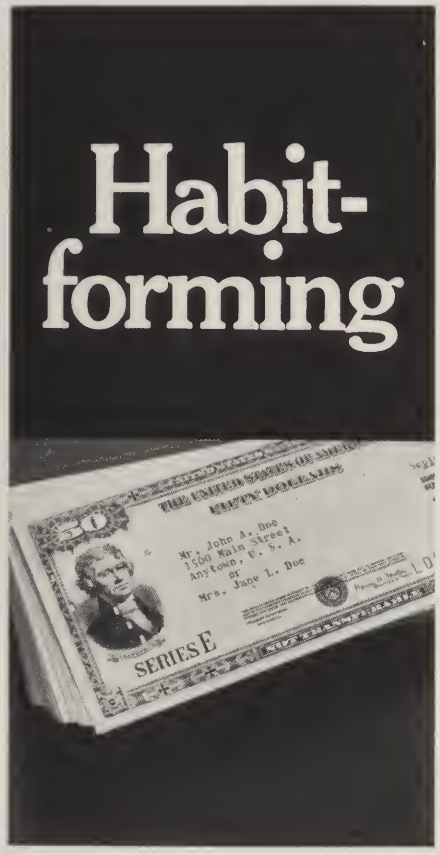
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2nd National Congress on Medical Ethics to be Held in October

The Judicial Council of the American Medical Association will hold its Second National Congress on Medical Ethics at the Drake Hotel, October 5–6, 1968.

The program, developed to tie in with AMA Law Week, is divided into three parts. One will deal with the ethics of medical practice and the future of medical practice, including the relationship of physicians and all those who work with them in providing health care to the public.

The second part of the program will be devoted to medical ethics and science and will delve into the "problems" seemingly created by medical experimentation and by the transplantation of organs from one human being to another.

The third position of the meeting will be devoted to medical ethics and discipline and will explore the several avenues available to the medical profession as it seeks to insure competency in the rendering of medical care.

Among the speakers at the conference will be F. J. L. Blasingame, MD, Executive Vice President of the AMA; Chauncey D. Leake, PhD, senior lecturer, department of history and philosophy, University of California, San Francisco; Irvine H. Page, MD, Research Division, Cleveland Clinic and recipient of AMA's Distinguished Service Award in 1964; Paul A. Freund, LLB, professor of law, Harvard Law School; J. Frank Walker, MD, eminent radiologist, Atlanta, Ga.; Milton D. Krueger, director of public and professional relations, California Medical Association; and Charles Forbes, LLB, partner in Los Angeles law firm of Musick, Peeler and Garrett.


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The Middle Ground of Component Therapy

ROBERT G. LANCASTER, MD

We are on middle ground right now as far as the use of blood is concerned. Transfusion therapy has grown sort of helter-skelter over the last 15 or 20 years. It has come a long way from the transfusion of sheep blood to humans, and from transfusion of blood from one individual to another without the realization of the dire consequences that may follow.

We have grown primarily along the path of technical safety almost to the point of absurdity in many instances. It is now only extremely rare that a hemolytic reaction is the result of technical error. However, progress in the actual use of blood has been somewhat neglected.

Blood has been transfused, sometimes whether the recipient needs it or not; it has been transfused almost exclusively as whole blood with very little regard as to what can be removed and used elsewhere, or for what can be substituted for whole blood to accomplish the end desired. This is not primarily the problem of the blood banker—it is the problem of the physician who actually prescribes blood for a given patient.

One of the major problems today, and probably for the next several years, is going to be a massive re-education campaign. We must keep reminding the physician that with all the blood components available, transfusing whole blood is one of the most wasteful ways of accomplishing a desired result in a given patient. Specific component therapy is much more efficient, and most of the time, makes more medical sense.

Transfusion therapy of the future will almost exclusively use components, and only rarely will whole blood be used. The idea behind the seminar included in this JOURNAL is to start people thinking in terms of component therapy.

Component therapy gives the patient only what he really needs, and in addition makes the use of blood much more effective. We are all painfully aware that much of such a precious material is wasted or not utilized to the fullest extent because of old-fashioned ideas and concepts. Let us start a new era of transfusion therapy—the almost exclusive use of components.

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ON THE COVER: This month's issue is devoted to the Seminar on Component Therapy, sponsored by the Medical and Chirurgical Faculty of Maryland, but organized by Edward E. Morse, Medical Director of the Baltimore Red Cross Blood Program. To honor Dr. Morse and Baltimore's excellent Red Cross Blood Program, the cover is a photograph of the Red Cross Baltimore Chapter Headquarters, located at the corner of St. Paul Street and 23rd Street.

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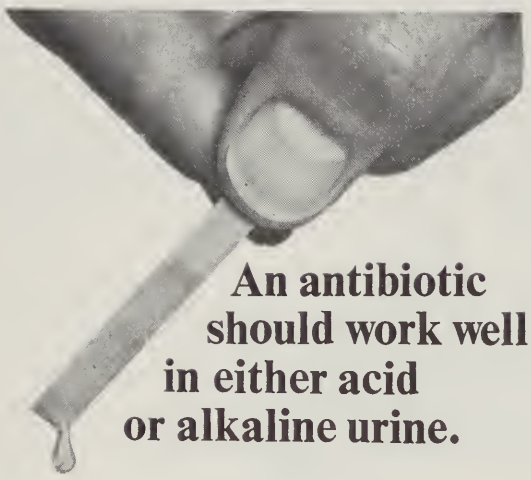
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Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system – anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin – maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney – rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth – dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; Tablets: film coated – 300 mg, 150 mg and 75 mg of demethylchlortetracycline HCl.

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SEPTEMBER 30-OCTOBER 1, 1968
AMERICAN MEDICAL ASSOCIATION COUNCIL ON OCCUPATIONAL HEALTH

Congress on Occupational Health—Twenty-eighth Annual: Waldorf-Astoria Hotel, New York, N.Y. Director: Henry F. Howe, MD. Contact: Council on Occupational Health, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

OCTOBER 2-3, 1968
AMERICAN MEDICAL ASSOCIATION/NATIONAL HEALTH COUNCIL

Fourth National Congress on Health Quackery—Protecting the Consumer: Drake Hotel, Chicago, Ill. Directors: F. J. L. Blasingame, MD, Peter G. Meek, MD. Attendance by invitation. Contact: Joseph A. Sabatier, Jr., MD, Chairman, Committee on Quackery, American Medical Association, 535 North Dearborn Street, Chicago, Ill. 60610.

OCTOBER 5-6, 1968
AMERICAN MEDICAL ASSOCIATION JUDICIAL COUNCIL

Second National Congress on Medical Ethics—Practical Consideration and Application of Ethical Principles in Everyday Practice: Drake Hotel, Chicago, Ill. Contact: American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

OCTOBER 7-11, 1968
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Computers in Medicine: University of Wisconsin Medical Center, Madison, Wis. Director: J. LeRoy Sims, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

OCTOBER 7-11, 1968
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Basic Mechanisms in Internal Medicine: Medical College of Virginia, Richmond, Va. Director: W. T. Thompson, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

OCTOBER 9-11, 1968
NEW YORK UNIVERSITY POSTGRADUATE MEDICAL SCHOOL

Postgraduate Course—Clinical Electrodiagnosis of Neuromuscular Diseases: Institute of Rehabilitation, Medicine Research Pavilion, New York University Medical Center, 400 East 34th Street, New York, N. Y. 10016. Chairman: Joseph Goodgold, MD. Contact: Office of the Recorder, New York University Postgraduate Medical School, 550 First Avenue, New York, N. Y. 10016.

OCTOBER 9-DECEMBER 11, 1968
INSTITUTE OF THE PENNSYLVANIA HOSPITAL

Postgraduate Course—Medicine and the Law: Pennsylvania Hospital, 1-3 P.M. Wednesdays (ten sessions). Contact: Sydney E. Pulver, MD, Director, 111 North 49th Street, Philadelphia, Pa. 19139.

OCTOBER 10-12, 1968
THE JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE/MARYLAND CHAPTER AAP

Postgraduate Course—Difficult Problems in Pediatrics and Pediatric Surgery: The Johns Hopkins Hospital, Baltimore. Contact: J. Alex Haller, Jr., MD, Robert Garrett Professor of Surgery, The Johns Hopkins Hospital, Baltimore, Md. 21205.

OCTOBER 11-12, 1968
HEART ASSOCIATION OF MARYLAND/MARYLAND HEART CHAPTERS

Meeting—HAM Annual Meeting: Statler Hilton Inn, Annapolis, Md. Contact: Heart Association of Maryland, 415 North Charles Street, Baltimore, Md. 21201.

OCTOBER 12, 1968
AMERICAN COLLEGE OF PHYSICIANS

Meeting—District of Columbia—Maryland Regional: Georgetown Medical School Hospital, Washington, D.C., 9 A.M.-4 P.M. Open to all physicians and medical students. Contact: Martin L. Singewald, MD, FACP, 11 East Chase Street, Baltimore, Md. 21202.

OCTOBER 19-24, 1968
AMERICAN ACADEMY OF PEDIATRICS

37th Annual Meeting—Infectious Mononucleosis—new developments, current status of organ transplantation, sex education—the parent's role, pediatric aspects of cigarette smoking, sudden death syndrome, drug use and abuse: Palmer House Hotel, Evanston, Ill. Contact: Department of Public Health Information, 1801 Hinman Avenue, Evanston, Ill. 60204.

OCTOBER 21-23, 1968
ASSOCIATION OF MILITARY SURGEONS OF THE U.S.

Convention—Quantity and Quality in Medical Care: Sheraton-Park Hotel, Washington, D.C. Director: Jack Masur, MD. Contact: Association of Military Surgeons of the U.S., 1500 Massachusetts Avenue, N.W., Washington, D.C. 20005.

OCTOBER 21-25
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Current Concepts of Neurology—Diagnosis and Treatment: University of Maryland School of Medicine, Baltimore, Md. Director: Erland Nelson, MD. Contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

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BALTIMORE, MD.

executive secretary's newsletter

September, 1968

MEDICAL NEWS SECTION

In our efforts to improve the format of the Maryland State Medical Journal, we have decided to eliminate personal items from this Newsletter and utilize them in a special section of the Journal devoted to MEDICAL NEWS. Members and others are encouraged to send material suitable for publication to the Editor, Maryland State Medical Journal, 1211 Cathedral St., Baltimore, Md., 21201

JET CHARTER FLIGHTS SET

Three Jet Charter Flights have been scheduled for Faculty members and their relatives for the latter part of October and November.

Two trips are scheduled to Rome and Florence; and one to London, England. The Rome and Florence trips leave on October 24 and November 10, returning from Florence on November 1 and November 18.

The London trip departs on November 21 and returns on November 27.

The 7 nights, 8 days Rome and Florence Trip includes deluxe accommodations and is all-inclusive in its price of $429.00; the 6 night, 7 day London trip carries a tag of $289.00, all-inclusive.

Full details are available through the Faculty office or Travel-Guide Agency, 416 N. Charles St, Balto, 21201

INSURANCE WARNING

Parents Alliance, Inc., of Winter Park, Florida, has been soliciting Obstetricians and their office secretaries with a scheme to "provide extra income." The company is not licensed to sell insurance in Maryland; and those persons who comply with the company's request for names of patients who are pregnant may find themselves in violation of the Insurance Code of Maryland for acting as an unlicensed insurance agent.

This opinion was obtained from the Insurance Commissioner after a query had been made to the Faculty office as to the legality and ethics of such activity by physicians.

CHILD ABUSE REPORTS

A recent report by the State Department of Public Welfare indicates that 23% of the cases of child abuse reported are through the school or child care facility. Hospitals or clinics come second with the Police Departments ranking third. Private physicians reported 3.7% of the total of 187 cases during the period studied.

EDUCATIONAL MAIL-IN

The offer of pamphlets for physicians' patients is still drawing daily receipt of mail-in cards. Geared to save the busy physician's time, the method provides an easy mechanism for patients to receive authoritative material on subjects of concern to them.

Full details can be obtained through the Faculty office.

MEDICAL PERSONALITIES DIE

Two outstanding figures of Maryland Medicine died during July. Walter N. Kirkman, Esq., one of two Honorary Faculty members, who served the Faculty for 13 years after 50 years of State service died on July 8.

Walter D. Wise, M.D., died suddenly on July 23, in his home. Dr. Wise had served as Faculty President, Secretary, Council Chairman and in many other capacities.

Both of these persons will be missed by the people of Maryland and the members of the Faculty.

PROJECT VIET NAM

Nearly 500 physicians have served 60-day terms of voluntary service in Viet Nam, under the AMA sponsored program to provide medical help to civilians in that country. Ten of these physicians were from Maryland. An average of 30 physicians has been maintained in Viet Nam; 35.0 for the past six months. Many individuals have volunteered their services for more than one tour of duty.

RULES OF PROCEDURE

The Board of Medical Examiners is adopting Rules of Procedure which shall apply to all formal hearings before the State Board of Medical Examiners. Details may be obtained from the Board offices.

John Sargent

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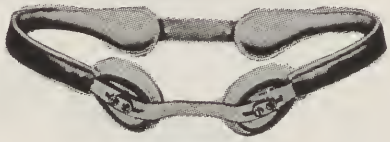
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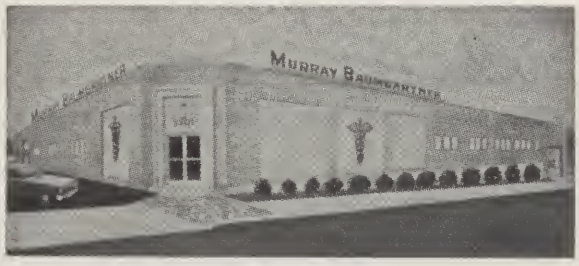
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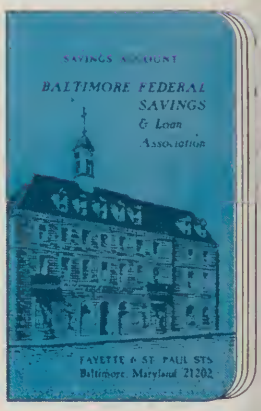
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DIVIDEND TO SEPTEMBER 30, 1968

BOOK MARK

When Baltimore Federal's quarterly dividends make their mark in your passbook, the reading gets especially interesting. Four times each year, the last day of September, December, March and June, your savings grow before your eyes to show a really profitable return. Savings may be added or withdrawn at any time in any amount. Your savings work for you in unsurpassed safety. Accounts are insured by the Federal Savings and Loan Insurance Corporation, an agency of the United States Government... are further backed by Baltimore Federal's reserves of over $24,000,000 Open or add to your savings account by the 10th and earn dividends for the entire month. Our new dividend period, starting October first, marks the most profitable time to start . . . the most profitable place . . . any of our seven offices . . . downtown at Fayette & St. Paul Sts. / Reisterstown Road Plaza / Eastpoint Shopping Center / Carney at 9609 Harford Rd. / Towson at 7 Alleghany Ave. / Yorktowne Plaza / Westminster at 6 E. Main Street.

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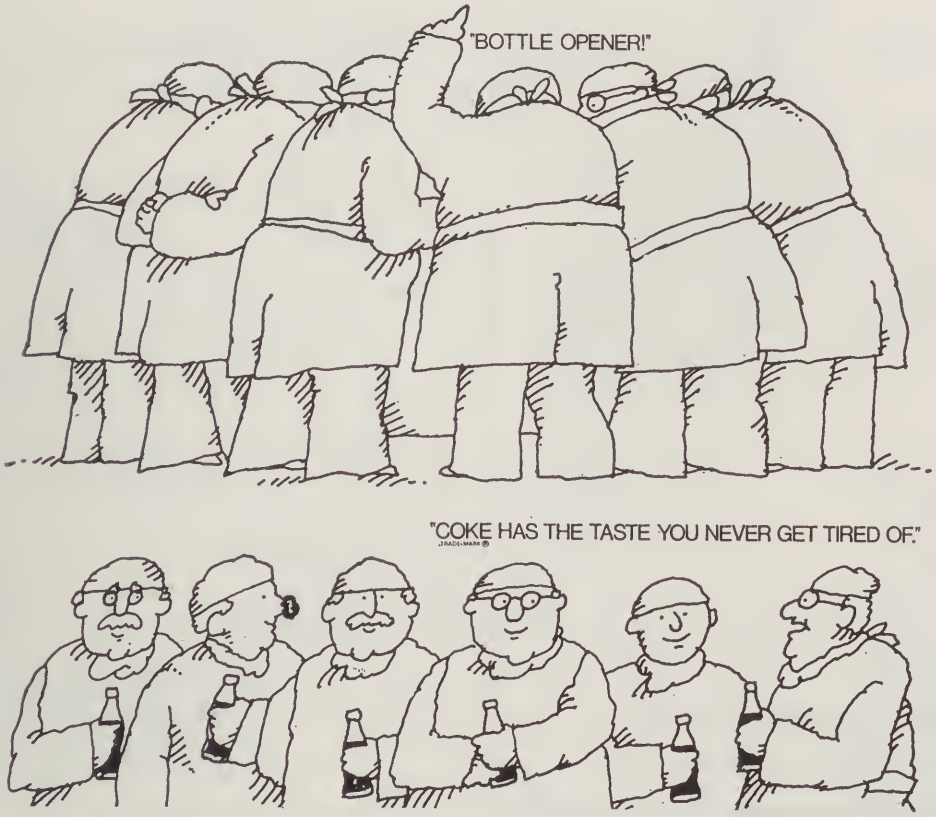
The traditional attitude of insurance underwriters toward the mentally retarded as being insurance risks has been cast aside by an insurance company in Indianapolis.

Institutional Life Insurance Co., organized in 1966 "to work in close cooperation with health, educational and charitable organizations," has announced that it is prepared to offer life insurance to the retarded "under extremely liberal conditions, at the same standard rates as for the non-retarded."

Thomas F. Cairns, president of the company, said that detailed actuarial studies and recent medical and scientific developments in the field of mental retardation led his company to this decision.

"Medical research is making valuable contributions which aid in the diagnosis and treatment of mental retardation," Cairns said. He added that the attitude of the general public and of educators is more and more being directed toward rehabilitation and special education than toward custodial care. He went on to explain that although there have been several studies concerning the mentally retarded who are institutionalized, "there can be found no impairment studies of the retarded among the general public which would lead to the conclusion that mental retardation has any significant effect upon life expectancy."

A year ago, Institutional Life "broke" with insurance tradition when it announced plans to issue life insurance on epileptics.



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Book Reviews

TODAY'S HEALTH GUIDE—REVISED EDITION, The American Medical Association, Chicago, Ill. 1968.

Published by the American Medical Association, this book is updated and current with medical information for the lay person. It is a well-rounded publication that can be of inestimable reference help to the practicing physician. Physicians can suggest to their patients that they purchase this book for their own use.

DYSLEXIA: DIAGNOSIS AND TREATMENT OF READING DISORDERS, by Arthur H. Keeney, MD, Virginia T. Keeney, MD; The C. V. Mosby Company, St. Louis, Mo. 1968.

This volume is the product of an intensive national conference that brought together 14 distinguished students of Dyslexia. The proceedings of this conference are directed primarily to opthalmic and medical practitioners although interest by persons in other fields is inherent.

This book will serve as a welcome addition to any library.



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INTERNAL MEDICINE BASED ON MECHANISMS OF DISEASE, Peter J. Talso, MD; Alexander P. Remenchik, MD; The C. V. Mosby Co., St. Louis, Mo. 1968.

The authors state, ". . . at the outset, certain principles and guidelines were established:

"1. Such a book should provide a description of the basic mechanisms that underlie diseases and the ways in which such disease processes induce signs and symptoms in the human being.

"2. For such a book to be useful to the student, it must include a description of the basic instruments necessary for the study of disease, such as the fundamentals of history taking, the technique of performing a physical examination, and an understanding of basic laboratory data.

"3. Such a book must be of a size convenient for the student to handle and carry with him."

The authors religiously followed these criteria and have, therefore, been able to publish a book that every student should have in his possession.

SCHOOL HEALTH SERVICES, by Charles C. Wilson, MD, Professor of Education and Public Health, Yale University, published by the National Education Association and the American Medical Association, Chicago, Ill., 1968.

This second edition has been revised and rewritten since the first edition was published in 1953.

It is designed as a reference for teachers and school administrators, for physicians and nurses, and for others concerned with any aspect of the school health program.

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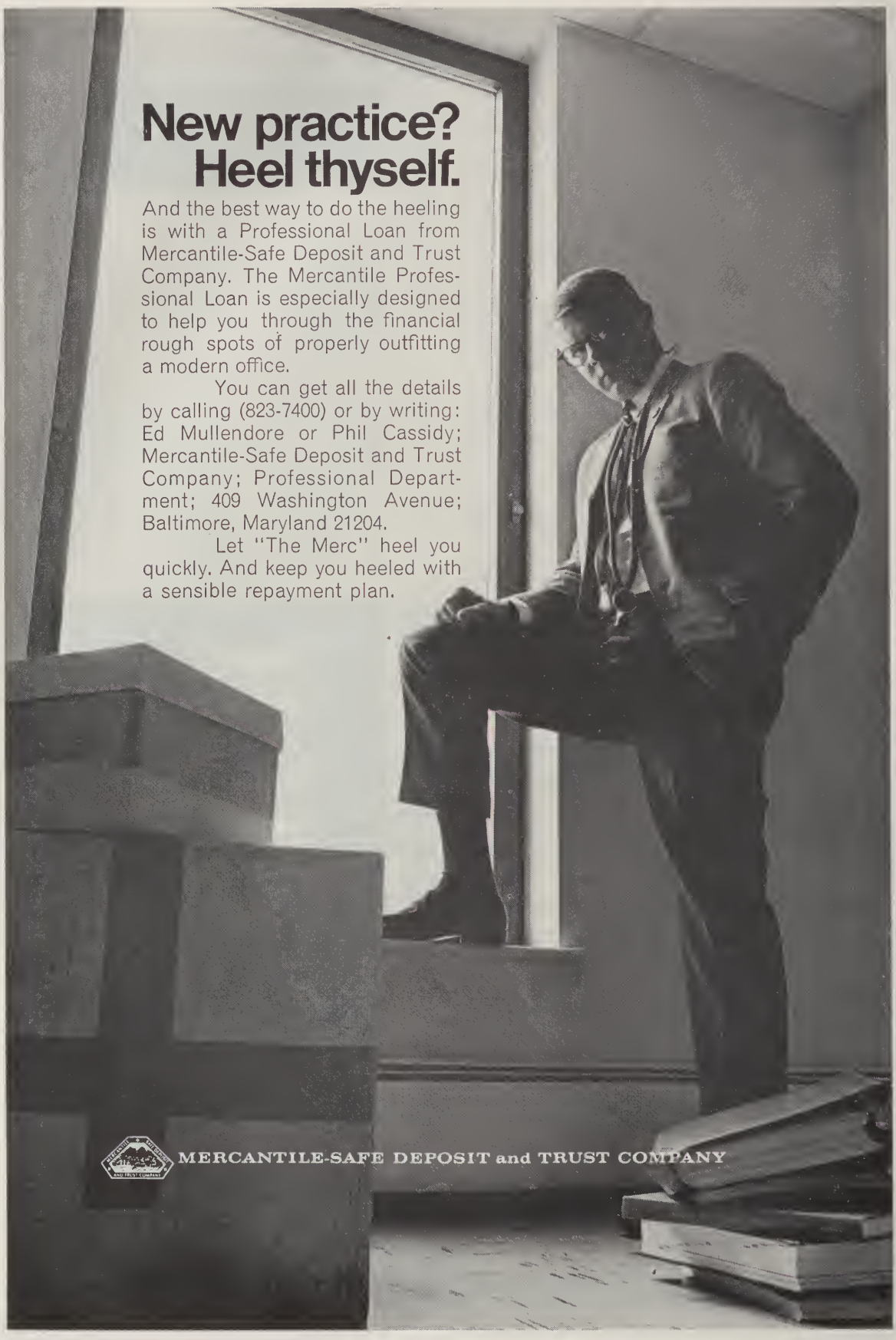
Diarrhea

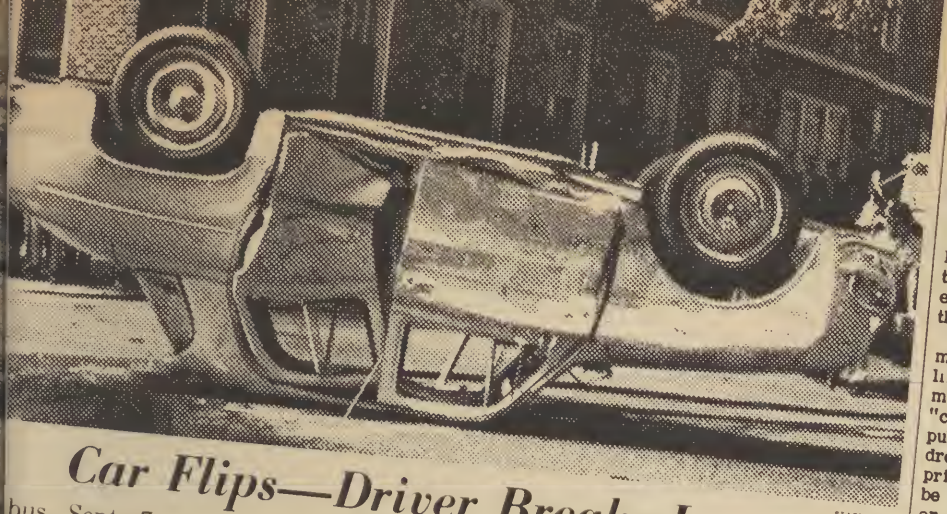
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For the patient who has been through an accident, the worry and anxiety following the experience may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—*to take the nervous "edge" off,* so the rest of the formula can control the pain more effectively.

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Phenaphen® with Codeine No. 2, No. 3, or No. 4 contains: *Phenobarbital* (¼ gr.), 16.2 mg. (Warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4). (Warning: may be habit forming).

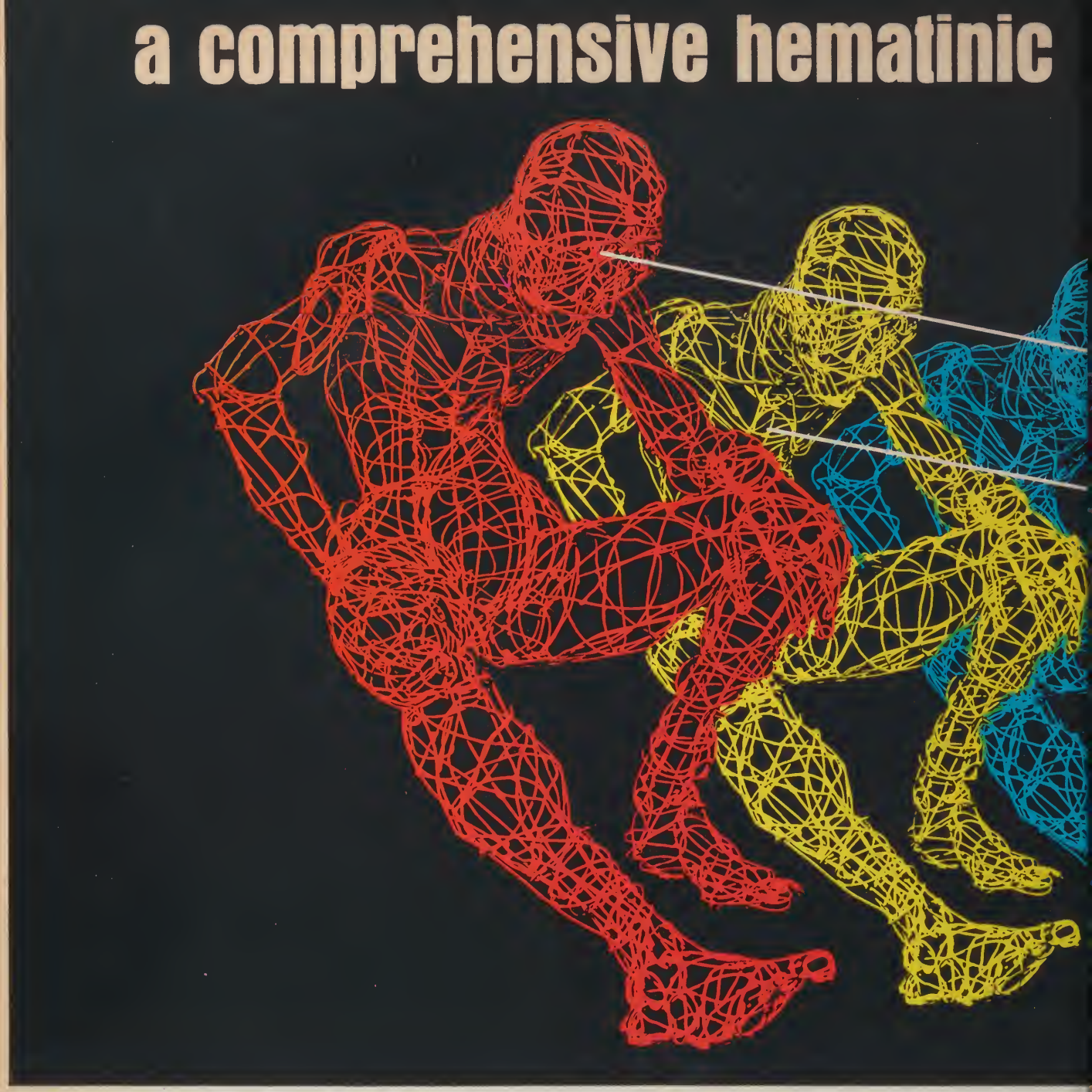
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Description: Each Pulvule® contains—

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Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5	mcg.
Iron, Elemental (as Ferrous Fumarate)	110	mg.
Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropriat investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequat vitamin B_{12} therapy may result in hematologic remission but neu rological progression. Adequate doses of vitamin B_{12} (parenteral or oral with potent intrinsic factor as in Trinsicon® [hematini concentrate with intrinsic factor, Lilly]) usually prevent, halt, o improve the neurological changes.

As with all preparations containing intrinsic factor, resistanc may develop in some cases of pernicious anemia to the potentia tion of absorption of physiological doses of vitamin B_{12}. If resist ance occurs, parenteral therapy, or oral therapy with so-calle massive doses of vitamin B_{12}, may be necessary. No single regi men fits all cases, and the status of the patient observed i follow-up is the final criterion for adequacy of therapy. Periodi



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clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500. [032566]

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Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

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WARNING: Transient lightheadedness or dizziness following NORFLEX-INJECTABLE may occur.

SIDE EFFECTS: Due mainly to anticholinergic action and usually at high dosage. They may include dryness of the mouth, tachycardia, palpitation, urinary hesitancy or retention, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, and drowsiness. Infrequently, mental confusion in the elderly, urticaria or other dermatoses. Side effects are usually eliminated by reduction in dosage. Two cases of aplastic anemia, with no established causal relationship, have been reported.

DOSAGE: **INJECTABLE** — Average adult dose: one ampul, 2 cc. (60 mg. orphenadrine citrate) I.M. or I.V. May be repeated every 12 hours. Relief may be maintained with one NORFLEX tablet b.i.d. **TABLETS** — Two tablets per day for adults, one in the morning, one in the evening. Each tablet contains 100 mg. orphenadrine citrate.

For full information, see Package Insert or P.D.R.

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Before prescribing, see complete information, including adverse effects reported with phenothiazines and symptoms and treatment of overdosage, in SK&F literature or *PDR*. The following is a brief precautionary statement.

Contraindications: Comatose states or the presence of large amounts of C.N.S. depressants.

Precautions: Potentiation of C.N.S. depressants may occur (reduce dosage of such agents when used concomitantly). Use with caution in patients with chronic respiratory disorders. Antiemetic effect may mask overdosage of toxic drugs or obscure other conditions. Administer in pregnancy only when necessary. Because of possible drowsiness use cautiously and warn patients who operate vehicles or machinery.

Adverse Reactions: Drowsiness; dry mouth; nasal congestion; constipation; amenorrhea; miosis; mild fever; weight gain; hypotensive effects, sometimes severe with I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosages (in rare instances, may persist); lactation and moderate breast engorgement (in females on high dosages); and less frequently, cholestatic jaundice (use cautiously in patients with liver disease). Adverse reactions occurring rarely, include: mydriasis; agranulocytosis; skin pigmentation; epithelial keratopathy; lenticular and corneal deposits (after prolonged substantial doses).

Available: Tablets, 10 mg., 25 mg., 50 mg., 100 mg. and 200 mg.; Spansule® capsules, 30 mg., 75 mg., 150 mg., 200 mg. and 300 mg.; Injection, 25 mg./cc.; Syrup, 10 mg./5 cc.; Suppositories, 25 mg. and 100 mg.

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THE 20th CENTURY ADOLESCENT

WEDNESDAY, NOVEMBER 13, 1968

A symposium for all physicians, their wives, professionally allied colleagues, and members of the legal profession who are concerned with the newer psychologies of adolescent behavior.

Time: Symposium—1:15 to 5:00 P.M.
Reception—5:00 P.M.
Banquet—6:00 P.M.

Place: The Eastwind
9000 Pulaski Highway
Baltimore, Maryland

Sponsors: Medical and Chirurgical Faculty of Maryland/Maryland Chapter, American Academy of General Practice/Maryland Chapter, American Academy of Pediatrics/Maryland Psychiatric Society/Maryland Society of Internal Medicine

Supported through a grant-in-aid from Geigy Pharmaceuticals, Ardsley, New York

PROGRAM

1:15 P.M.—*Symposium Welcome.*
John Whitridge, Jr., MD
Chairman, Committee on Postgraduate Education, Preventive Medicine, and Public Health, Medical and Chirurgical Faculty

1:20 P.M.—*The Adolescent Patient: An Overview.* **Sheldon D. Glass, MD**
Co-Director Family and Youth Center; and Co-Psychiatrist in Charge of Adolescent Psychiatry Center, The Johns Hopkins University School of Medicine, Baltimore

1:40 P.M.—*Implications of the Sex Revolution for the Adolescent's Search for Sexual Identity.*
James F. Masterson, Jr., MD
Associate Professor of Clinical Psychiatry, Cornell University Medical Center; and Attending Psychiatrist, Payne Whitney Clinic, New York

2:15 P.M.—*Drug Addiction, Psychedelic Hoaxes and Modern Youth.* **Dale G. Friend, MD**
Assistant Professor of Medicine, Harvard Medical School, Boston

2:50 P.M.—Recess

3:05 P.M.—*Depression in Adolescents and College Students.* **Francis J. Braceland, MD**
Editor, *American Journal of Psychiatry;* and Senior Consultant, Institute of Living, Hartford

3:40 P.M.—*Legal Obligations in Dealing with the Rebellious, Odd-Ball Adolescent.*
William J. Curran, LLM, SMHyg
Professor of Health Law, Harvard Medical School, Boston

4:15 P.M.—*Panel Sessions: Questions and Answers*
Moderator: Dr. Glass
Panelists: Drs. Braceland, Curran, Friend, and Masterson

5:00 P.M.—*Cocktail Reception*
For physicians, their wives and guests

6:00 P.M.—*The Changing Status of Adolescents in the Modern World.* **Margaret Mead, PhD**
Curator of Ethnology, The American Museum of Natural History; and Adjunct Professor of Anthropology, Columbia University, New York

Admission tickets for symposium lectures are free, but because of the current widespread interest in the subject, all applications for admission tickets will be handled strictly in order of receipt. There is a nominal charge of five dollars ($5) per person for the cocktail reception and banquet. Mail reservations by November 7 to:

John Whitridge, Jr., MD
P. O. Box 9791
Baltimore, Maryland 21204

For further information call the Medical and Chirurgical Faculty office:
(301)539-0872

A complete program will be mailed to all physicians in Maryland and other individuals may receive a copy by calling the Faculty office.

Suggestion for Curbing Time Spent on Business Matters

Thanks to Medicare and health insurance, every physician's office time is being spent more and more on business matters.

To see if physicians could use a big helping hand, Marion Laboratories asked its panel of MDs, "Would you be interested in a nationwide central organization created exclusively to help physicians in business management and provide patient service for their medical practice?"

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In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

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Tandearil® in Osteoarthritis
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Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.
Warning: Tandearil is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.
Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.
Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reacti-

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At 46, her knees still look good on the outside. But inside, there may be the familiar picture of osteoarthritis.



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Of course, Tandearil is not for every osteoarthritic. Select your patients carefully and follow them in line with the Contraindications, Precautions, Warning, and Adverse Reactions listed below.

But for many aspirin-stubborn osteoarthritics, let Tandearil ease the unwelcome pain breaks of osteoarthritis.

Tandearil®
oxyphenbutazone

vate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis) or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity, angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

For complete details, please see full Prescribing Information.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily. In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and other factors influencing drug response. Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

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This combination of amphetamines may be useful as an adjunct in the management of certain forms of obesity where an appetite depressant is indicated.

Contraindications: Hypertension, advanced arteriosclerosis, coronary artery disease, cardiac arrhythmias, peripheral vascular disease, states of undue restlessness, anxiety, excitement, agitated depression, hyperthyroidism, idiosyncrasy to amphetamine, concomitant administration of a monoamine oxidase inhibitor. **Precautions:** Use with caution in individuals with anorexia, insomnia, vasomotor instability, asthenia, psychopathic personality, a history of homicidal or suicidal tendencies, and individuals who are known to be hyperractive to sympathomimetic agents, or emotionally unstable individuals who are known to be susceptible to drug abuse. Certain monoamine oxidase inhibitors may potentiate the action of Obetrol. **Side Effects:** The most common side effects attended with the use of amphetamines include nervousness, excitability, euphoria, insomnia, dryness of mouth, nausea, vertigo, constipation, and headache.

Dosage and Administration: Initial adult dose is one-half to one 'Obetrol-10' tablet daily, preferably one-half to one hour before meals. This may be gradually increased to one 'Obetrol-10' or 'Obetrol-20' tablet one to three times daily as indicated. **Supplied:** Tablets scored, in bottles of 100. 500, and 1000.

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SEPTEMBER 27, 1968 — 12:30 P.M.
THE CANCER PROBLEM — 1968

Harlan Firminger, MD
Professor of Pathology
University of Maryland School of Medicine

Cancer is the tissue manifestation of unregulated cellular growth and proliferation which invades, distorts, displaces and often destroys normal tissues and interferes with their function. Control of established disease by whatever means is always temporary and a losing defensive battle. Continuing research into the fundamental controlling mechanisms of cellular genetics, replication and growth still offer our greatest hope for prevention.

Sponsor: **Frederick Memorial Hospital**

Replays:	Monday, September 30, 1968	12:30 P.M.
	Wednesday, October 2, 1968	9:00 A.M.
		2:00 P.M.
		8:00 P.M.

OCTOBER 4, 1968 — 12:30 P.M.
OFFICE ORTHOPEDICS IN THE INFANT

George N. Austin, MD
Professor and Chairman of Orthopedic Surgery
University of Maryland School of Medicine

This talk will emphasize the diagnostic criteria for; congenital dislocation of the hip, torticollis, Erb's, palsy, trigger thumbs, spastic cerebral palsy, flat feet and club feet, in the infant. For the toddler age child, minor foot deformities, knock-knees, bowed-legs, and internal tibial torsion, will be discussed from the standpoint of diagnosis and indications for treatment.

Sponsor: **Sacred Heart Hospital**

Replays:	Monday, October 7, 1968	12:30 P.M.
	Wednesday, October 9, 1968	9:00 A.M.
		2:00 P.M.
		8:00 P.M.

OCTOBER 11, 1968 — 12:30 P.M.
OFFICE ORTHOPEDICS IN THE ADOLESCENT

T. H. Morgan, MD
Assistant Professor of Orthopedic Surgery
University of Maryland School of Medicine

Patients in the adolescent age group when seen in the office usually fall into two major categories; those for follow-up of a pre-existing orthopedic condition for which they are under continued supervision, and those with lesions which tend to occur in this age period. This talk will be concerned primarily with conditions arising in this age group resulting from trauma, scoliosis, slipped capital femoral epiphysis, and adolescent coxa vara.

Sponsor: **Peninsula General Hospital**

Replays:	Monday, October 14, 1968	12:30 P.M.
	Wednesday, October 16, 1968	9:00 A.M.
		2:00 P.M.
		8:00 P.M.

OCTOBER 18, 1968 — 12:30 P.M.
OFFICE ORTHOPEDICS IN THE ADULT

A. Gibson Packard, Jr. MD
Instructor In Orthopedic Surgery
The Johns Hopkins University School of Medicine

The ten most common reasons for a patient appearing in the office with primary shoulder pain will be discussed. Points in the history, physical diagnosis, and x-ray will be illustrated. Treatment of each entity will also be reviewed.

Sponsor: **Eugene Leland Memorial Hospital**

Replays:	Monday, October 21, 1968	12:30 P.M.
	Wednesday, October 23, 1968	9:00 A.M.
		2:00 P.M.
		8:00 P.M.

OCTOBER 25, 1968 — 12:30 P.M.
CANCER IN INFANCY AND CHILDHOOD

William H. Zinkham, MD
Associate Professor of Pediatrics
Children's Medical and Surgical Center
The Johns Hopkins University School of Medicine

Leukemia and cancer of childhood now comprise a major portion of pediatric illnesses. Early recognition of these disorders is imperative to appropriate therapy, with total cure being the ultimate objective. Three major therapeutic implements are available; surgery, radiotherapy and chemotherapy. The clinical recognition, appropriate therapy and survival figures will be presented for some of the major childhood cancers.

Sponsor: **Frederick Memorial Hospital**

Replays:	Monday, October 28, 1968	12:30 P.M.
	Wednesday, October 30, 1968	9:00 A.M.
		2:00 P.M.
		8:00 P.M.

NOVEMBER 1, 1968 — 12:30 P.M.
TUBERCULOSIS — DIAGNOSIS AND MANAGEMENT

George W. Comstock, MD
Professor of Epidemiology
The Johns Hopkins University School of Hygiene and Public Health

Reactors to an intermediate dose of tuberculin have a significant risk of developing tuberculosis at some time during their lives. This is particularly true for household associates of known active cases, recent converters, persons with pulmonary scars, diabetics, and patients receiving long-term therapy with corticosteroids. Treatment with isoniazid has been shown to reduce this risk markedly. Physicians in private practice now have a real opportunity to protect their patients, and their communities, against tuberculosis.

Sponsor: **Cumberland Memorial Hospital**

Replays:	Monday, November 4, 1968	12:30 P.M.
	Wednesday, November 6, 1968	9:00 A.M.
		2:00 P.M.
		8:00 P.M.

Supported in part by a grant from Merck, Sharp and Dohme

NOVEMBER 8, 1968 — 12:30 P.M.
LUNG ABSCESS

Jack Love, MD
Assistant Professor of Surgery
The Johns Hopkins University School of Medicine, and
Assistant Chief of Surgery,
Baltimore City Hospitals

Despite an armamentarium of effective antibiotics lung abscess continues to be encountered. The various causes will be discussed. A practical guide for the evaluation of patients presenting with pulmonary abscess will be described, along with the results of current methods of management.

Sponsor: **Provident Hospital**

Replays:	Monday, November 11, 1968	12:30 P.M.
	Wednesday, November 13, 1968	9:00 A.M.
		2:00 P.M.
		8:00 P.M.

NOVEMBER 15, 1968 — 12:30 P.M.
PNEUMONIA

Patricia Charache, MD
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine, and
Assistant Chief of Medicine,
Baltimore City Hospitals

Choice of therapy in pneumonia requires a knowledge of the pathophysiology of pneumonia, the probable etiologic agent and knowledge of the activity of available drugs. Complications can arise due to their inappropriate use. The theme of this presentation will be an exploration of the problem, emphasizing some of the therapeutic pitfalls to be avoided.

Sponsor: **Harford Memorial Hospital**

Replays:	Monday, November 18, 1968	12:30 P.M.
	Wednesday, November 20, 1968	9:00 A.M.
		2:00 P.M.
		8:00 P.M.

NOVEMBER 22, 1968 — 12:30 P.M.
MELANOMA AND CANCER OF THE SKIN

Joseph W. Burnett, MD
Assistant Professor of Medicine In Dermatology
University of Maryland School of Medicine

A discussion of skin malignancies including epitheliomas and myomas will be made. The pathogenesis, clinical manifestations, complications, prognosis and methods of treatment will be discussed. The advantage of treatment programs such as surgical excision, radiation, chemotherapy, cryosurgery and chemosurgery will be made. Some new advances of pathogenesis of melanomas will be outlined.

Sponsor: **Frederick Memorial Hospital**

Replays:	Monday, November 25, 1968	12:30 P.M.
	Wednesday, November 27, 1968	9:00 A.M.
		2:00 P.M.
		8:00 P.M.

NOVEMBER 29, 1968 — 12:30 P.M.
ASTHMA

Thomas E. VanMetre, Jr., MD
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine

Asthma ranks high as a cause of chronic respiratory disease. Care of patients with this disease frequently taxes the skill of the practitioner. Aspects of pathophysiology, inducing factors, complications and management will be explored and discussed.

Sponsor: **Maryland General Hospital**

Replays:	Monday, December 2, 1968	12:30 P.M.
	Wednesday, December 4, 1968	9:00 A.M.
		2:00 P.M.
		8:00 P.M.

DECEMBER 6, 1968 — 12:30 P.M.
DIAGNOSTIC PROBLEMS IN RHEUMATOID ARTHRITIS

Alexander S. Townes, MD
Assistant Chief of Medicine,
Baltimore City Hospitals

The diagnostic features of rheumatoid arthritis will be discussed briefly reviewing the characteristic clinical features of the articular and extra-articular manifestations of the disease. There will be a brief review of other syndromes which may be confused with rheumatoid disease and how one may differentiate them clinically from rheumatoid arthritis. This discussion will also include a resumé of the clinical significance and interpretation of serologic tests for rheumatoid factor.

Sponsor: **Washington County Hospital**

Replays:	Monday, December 9, 1968	12:30 P.M.
	Wednesday, December 11, 1968	9:00 A.M.
		2:00 P.M.
		8:00 P.M.

DECEMBER 13, 1968 — 12:30 P.M.
MANAGEMENT OF RHEUMATOID ARTHRITIS

A. Lewis Kolodny, MD
Director, Department of Rheumatology
North Charles General Hospital

The treatment of various stages of rheumatoid arthritis will be discussed. Practical aspects of proper therapeutic modalities such as drugs, physical medicine and surgical correction will be presented. Furthermore, emphasis will be placed on early recognition and treatment of this disease.

Sponsor: **Anne Arundel General Hospital**

Replays:	Monday, December 16, 1968	12:30 P.M.
	Wednesday, December 18, 1968	9:00 A.M.
		2:00 P.M.
		8:00 P.M.

DECEMBER 20, 1968 — 12:30 P.M.

ANKYLOSING (RHEUMATOID) SPONDYLITIS

Harry F. Klinefelter, MD
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine

This disorder most commonly afflicts young men. Early diagnosis is mandatory for optimum therapeutic results. This presentation will stress these points and discuss appropriate therapy and the beneficial effects that can be obtained.

Sponsor: **Greater Baltimore Medical Center**

Replays: Monday, December 23, 1968 12:30 P.M.

JANUARY 10, 1969 — 12:30 P.M.

THE BLEEDING PATIENT

Philip D. Zieve, MD
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine, and
Assistant Chief of Medicine,
Baltimore City Hospitals

The important features of the history and physical examination of a patient with an apparent hemorrhagic diathesis will be discussed. The various tests performed in the laboratory to establish a precise diagnosis in such a patient will be described. Appropriate therapy will be outlined.

Sponsor: **Prince George's General Hospital**

Replays: Monday, January 13, 1969 12:30 P.M.
Wednesday, January 15, 1969 9:00 A.M.
2:00 P.M.
8:00 P.M.

JANUARY 17, 1969 — 12:30 P.M.

ERYTHROBLASTOSIS FETALIS

Julius R. Krevans, MD
Associate Professor of Medicine
The Johns Hopkins University School of Medicine, and
Chief of Medicine,
Baltimore City Hospitals

The ultimate goal of medicine is prevention of disease. The most common cause of erythroblastosis can now be considered a candidate for eradication. This talk will include a discussion of the cause of erythroblastosis fetalis and of the experiments performed by a number of groups in recent years to prevent the occurrence of the disease.

Sponsor: **Harford Memorial Hospital**

Replays: Monday, January 20, 1969 12:30 P.M.
Wednesday, January 22, 1969 9:00 A.M.
2:00 P.M.
8:00 P.M.

JANUARY 24, 1969 — 12:30 P.M.

CYTOLOGY IN THE DIAGNOSIS AND TREATMENT OF CANCER

John K. Frost, MD
Associate Professor of Pathology
The Johns Hopkins University School of Medicine

A critical evaluation of the value of clinical cytopathology in the practice of medicine. This discussion will involve mainly the genitourinary, gastrointestinal, and respiratory systems, with a survey of the clinical procedures for obtaining specimens, interpretation of results, pitfalls to be avoided, and obtainable clinical assistance.

Sponsor: **Frederick Memorial Hospital**

Replays: Monday, January 27, 1969 12:30 P.M.
Wednesday, January 29, 1969 9:00 A.M.
2:00 P.M.
8:00 P.M.

JANUARY 31, 1969 — 12:30 P.M.

IRON DEFICIENCY

C. Lockard Conley, MD
Professor of Medicine
The Johns Hopkins University School of Medicine

The causes, manifestations and clinical implications of iron deficiency will be discussed and illustrated by representative cases. Emphasis will be placed on differential diagnosis and treatment. Discussion will include the economical and appropriate use of laboratory tests and their interpretation.

Sponsor: **Greater Baltimore Medical Center**

Replays: Monday, February 3, 1969 12:30 P.M.
Wednesday, February 5, 1969 9:00 A.M.
2:00 P.M.
8:00 P.M.

FEBRUARY 7, 1969 — 12:30 P.M.

CONSTRICTIVE AND RESTRICTIVE HEART DISEASE

Kenneth B. Lewis, MD
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine, and
Assistant Chief of Medicine
Baltimore City Hospitals

This discussion will review briefly the typical presentation of patients with constrictive pericardial disease and will then emphasize several unusual ways in which this entity may be present. The difficulty in separating, on clinical examination and even at times on laboratory evidence, constrictive pericardial disease for which surgical therapy offers chance for improvement from restrictive myocardial disease for which there is no specific treatment will be discussed. The current diagnostic methods for evaluating patients suspected of having this form of heart disease will be reviewed.

Sponsor: **Easton Memorial Hospital**

Replays: Monday, February 10, 1969 12:30 P.M.
Wednesday, February 12, 1969 9:00 A.M.
2:00 P.M.
8:00 P.M.

FEBRUARY 14, 1969 — 12:30 P.M.
VENOUS VASCULAR DISEASE

J. Alex Haller, Jr., MD
Associate Professor of Pediatric Surgery
The Johns Hopkins University School of Medicine

This talk will be on the pathophysiology and management of deep thrombophlebitis and will include the treatment of thromboembolism, massive venous occlusion, and the post-phlebitic limb. The operative and non-operative treatment of deep thrombophlebitis will be discussed and pertinent case material will be included.

Sponsor: Provident Hospital

Replays:	Monday, February 17, 1969	12:30 P.M.
	Wednesday, February 19, 1969	9:00 A.M.
		2:00 P.M.
		8:00 P.M.

FEBRUARY 21, 1969 — 12:30 P.M.
HYPERTENSION

R. Patterson Russell, MD
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine

In considering treatment of the hypertensive patient the following will be reviewed: role of the initial evaluation; aims of and indications for treatment; currently effective pharmacotherapeutic agents and results of therapy.

Sponsor: Baltimore County General Hospital

Replays:	Monday, February 24, 1969	12:30 P.M.
	Wednesday, February 26, 1969	9:00 A.M.
		2:00 P.M.
		8:00 P.M.

FEBRUARY 28, 1969 — 12:30 P.M.
TROPHOBLASTIC DISEASE

Griff T. Ross, MD
National Institutes of Health
Bethesda, Maryland

Results of chemotherapy of gestational trophoblastic neoplasms — metastatic and non-metastatic — will be presented. Factors influencing results will be analyzed and discussed. The diagnostic maneuvers necessary to early recognition will be emphasized.

Sponsor: Frederick Memorial Hospital

Replays:	Monday, March 3, 1969	12:30 P.M.
	Wednesday, March 5, 1969	9:00 A.M.
		2:00 P.M.
		8:00 P.M.

MARCH 7, 1969 — 12:30 P.M.
G.I. BLEEDING

Marvin M. Schuster, MD
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine, and
Assistant Chief of Medicine,
Baltimore City Hospitals

A practical approach to the diagnosis and treatment of gastrointestinal hemorrhage will be discussed. This will include both the acute massive bleed as well as chronic hemorrhage and will emphasize diagnostic technicalities which have been found useful.

Sponsor: Easton Memorial Hospital

Replays:	Monday, March 10, 1969	12:30 P.M.
	Wednesday, March 12, 1969	9:00 A.M.
		2:00 P.M.
		8:00 P.M.

MARCH 14, 1969 — 12:30 P.M.
THE PATIENT WITH DIARRHEA — MALABSORPTION SYNDROME

Vernon M. Smith, MD
Professor of Clinical Medicine and Head
Department of Medicine,
Mercy Hospital

Diarrhea is a common disorder which usually is benign, self-limited and requires no treatment. Persistent diarrhea, on the other hand, may denote important underlying disease, including malabsorption. The talk will be directed toward a logical distinction among the malabsorption syndromes, according to their underlying pathophysiological states; and toward the practical management of patients suspected of having malabsorption syndrome.

Sponsor: Prince George's General Hospital

Replays:	Monday, March 17, 1969	12:30 P.M.
	Wednesday, March 19, 1969	9:00 A.M.
		2:00 P.M.
		8:00 P.M.

MARCH 21, 1969 — 12:30 P.M.
ABDOMINAL PAIN

David Skinner, MD
Assistant Professor of Surgery
The Johns Hopkins University School of Medicine

The differential diagnosis of upper abdominal pain includes common conditions such as hiatal hernia, ulcer, pancreatitis, pancreatic carcinoma, biliary tract disorders, aortic aneurysms, and ischemic mesenteric vascular disease. Physiologic and radiographic tests useful in establishing specific diagnoses will be described, and indications for surgical or medical treatment will be presented.

Sponsor: Cumberland Memorial Hospital

Replays:	Monday, March 24, 1969	12:30 P.M.
	Wednesday, March 26, 1969	9:00 A.M.
		2:00 P.M.
		8:00 P.M.

MARCH 28, 1969 — 12:30 P.M.

CANCER OF THE BREAST

Edward F. Lewison, MD
Assistant Professor of Surgery
The Johns Hopkins University School of Medicine

A review of the historical and epidemiologic aspects of breast cancer will be presented. Prompt detection and diagnosis will be discussed. Treatment will be considered from the standpoint of both the operable patient and the inoperable patient with advanced or metastatic disease.

Sponsor: **Frederick Memorial Hospital**

Replays:	Monday, March 31, 1969	12:30 P.M.
	Wednesday, April 2, 1969	9:00 A.M.
		2:00 P.M.
		8:00 P.M.

APRIL 4, 1969 — 12:30 P.M.

URINARY TRACT INFECTION

John D. Young, MD
Professor of Urology
University of Maryland School of Medicine

There is increasing evidence that bacteria seldom invade the urinary tract without the help of some contributing factor such as injury to the urothelium or mechanical interference with urine flow. There is experimental evidence that "toxins" from E. coli have an inhibiting effect on ureteral peristalsis which might help perpetuate infection. The diagnosis and treatment of urinary tract infections is discussed with the above principles as a guide. Illustrative x-rays and diagrams will be shown.

Sponsor: **Sacred Heart Hospital**

Replays:	Monday, April 7, 1969	12:30 P.M.
	Wednesday, April 9, 1969	9:00 A.M.
		2:00 P.M.
		8:00 P.M.

APRIL 18, 1969 — 12:30 P.M.

URINARY INCONTINENCE

Edward W. Campbell, MD
Assistant Professor of Urology
University of Maryland School of Medicine

Urinary incontinence will be considered as a symptom, representing a variety of clinical entities. While commonly a manifestation of local disease affecting the bladder and its supporting structures, incontinence may herald the onset of more distant and serious disease. Differential factors in the historical and physical manifestations of these various etiologic entities will be emphasized. Certain diagnostic procedures and treatment will be discussed.

Sponsor: **Maryland General Hospital**

Replays:	Monday, April 21, 1969	12:30 P.M.
	Wednesday, April 23, 1969	9:00 A.M.
		2:00 P.M.
		8:00 P.M.

APRIL 25, 1969 — 12:30 P.M.

MALIGNANCIES OF THE CENTRAL NERVOUS SYSTEM

John A. Wagner, MD
Professor of Neuropathology
University of Maryland School of Medicine

The subject of intracranial tumor is reviewed with appropriate clinical-pathologic correlation. The salient features of the more important primary and secondary tumors is reviewed. Included also are notes on pathogenisis, relation to trauma and present status of research.

Sponsor: **Frederick Memorial Hospital**

Replays:	Monday, April 28, 1969	12:30 P.M.
	Wednesday, April 30, 1969	9:00 A.M.
		2:00 P.M.
		8:00 P.M.

MAY 2, 1969 — 12:30 P.M.

CARCINOMA OF THE THYROID

Joseph B. Workman, MD
Associate Professor of Medicine
University of Maryland School of Medicine

Current knowledge concerning the causes, clinical classifications and methods of therapy in thyroid carcinoma will be discussed. Emphasis will be placed on the effect of age at onset, pathologic type, duration of disease and type of therapy upon eventual outcome.

Sponsor: **Peninsula General Hospital**

Replays:	Monday, May 5, 1969	12:30 P.M.
	Wednesday, May 7, 1969	9:00 A.M.
		2:00 P.M.
		8:00 P.M.

MAY 9, 1969 — 12:30 P.M.

DIABETES

Thaddeus E. Prout, MD
Associate Professor of Medicine
The Johns Hopkins University School of Medicine, and
Chief of Medicine,
Greater Baltimore Medical Center

Diabetes calls for long term management and a cooperative effort between patient and physician. The clinical problems encountered in the management of the diabetic is the subject of this presentation. Both prevention and therapy will be considered.

Sponsor: **Washington County Hospital**

Replays:	Monday, May 12, 1969	12:30 P.M.
	Wednesday, May 14, 1969	9:00 A.M.
		2:00 P.M.
		8:00 P.M.

MAY 16, 1969 — 12:30 P.M.
HYPOTHYROIDISM

John G. Wiswell, MD
Associate Professor of Medicine
University of Maryland School of Medicine

A discussion of etiologic factors, unusual manifestations, and the indications for the various types of preparations used in treating hypothyroidism. The management of a patient with myxedema coma will also be discussed.

Sponsor: **Anne Arundel General Hospital**
Replays: Monday, May 19, 1969 — 12:30 P.M.
Wednesday, May 21, 1969 — 9:00 A.M.
2:00 P.M.
8:00 P.M.

MAY 23, 1969 — 12:30 P.M.
CANCER RESEARCH

Nathaniel I. Berlin, MD
Clinical Director National Cancer Institute
National Institutes of Health,
Bethesda, Maryland

Cancer research will be reviewed from three standpoints. Etiology, especially our current understanding of viral etiology. New diagnostic applications, principally in cytology and mammography. Therapeutic research oriented towards where we stand with various modalities.

Sponsor: **Frederick Memorial Hospital**
Replays: Monday, May 26, 1969 — 12:30 P.M.
Wednesday, May 28, 1969 — 9:00 A.M.
2:00 P.M.
8:00 P.M.

CONTINUING PROGRAMS

(Heard at participating hospitals only)

MONDAY through FRIDAY AFTERNOONS — 4:00-5:00 P.M.
PEDIATRIC STAFF ROUNDS
The Johns Hopkins Hospital

TUESDAY MORNINGS — 11:30 A.M.
MEDICAL GRAND ROUNDS
University of Maryland Hospital

FRIDAY AFTERNOONS — 2:00 P.M.
NEUROLOGY GRAND ROUNDS
University of Maryland Hospital

SATURDAY MORNINGS — 8:00 A.M.
PEDIATRIC GRAND ROUNDS
The Johns Hopkins Hospital

SATURDAY MORNINGS — 10:00 A.M.
MEDICAL GRAND ROUNDS
The Johns Hopkins Hospital

SPECIAL INTEREST PROGRAMS

Joint Anesthesia Study Committee of the Baltimore City Medical Society and the City Health Department

Presentation of Cases
7:30 p.m.

September 24
October 22
November 26
January 28
February 25
March 25
April 22
May 27

Participating hospitals:
Anne Arundel General, Annapolis
Baltimore City, Baltimore
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Other locations:
Medical and Chirurgical Faculty, Baltimore
State Office Building, Baltimore
Hospital Council of Maryland, Inc., Baltimore

Additional programs published monthly in Maryland State Medical Journal

For further information contact:
Medical and Chirurgical Faculty of the State of Maryland
1211 Cathedral Street, Baltimore, Maryland 21201
539-0872
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State Department of Health, 301 W. Preston Street
Baltimore, Maryland 21201 383-3010 Ext. 8722

Supported in part by a grant from Merck, Sharp and Dohme

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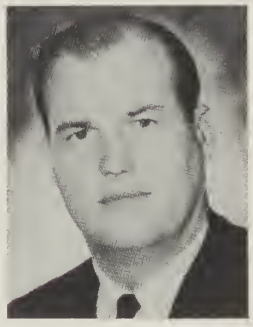
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The Month in Washington

"Improving the quality of life in this country requires that far greater national effort be devoted to reducing the incidence of preventable diseases, accidents and premature death."

This was the theme of a proposal to President Johnson to establish a Commission on Disease Prevention and Health Protection, appointed by the President, to make recommendations within a year.

The President was told that "to continue the present national emphasis upon treatment and after-the-fact remedies, as opposed to prevention, must be regarded as a failure of the health professions to adequately protect the public."

Said the plan's sponsors, headed by **Senator Warren Magnuson** (D., Wash.), Chairman of the Senate Commerce Committee:

> "Many of the diseases currently prevalent can be prevented entirely. Others can be detected and cured in the early stages. In some cases, it is simply a question of instilling awareness, recognizing symptoms or the importance of diet, and exercise. Technical personnel and automated laboratory and computerized recording procedures can utilize known techniques to operate comprehensive screening programs. These prevention and early detection programs can save money and conserve scarce physician time. People can be educated to expect health rather than to tolerate illness, to demand prevention rather than to admire belated treatment.
>
> "Benefits can be derived through legislation. Others will accrue through public and professional education. Still further benefits would come from financial support for special professional and non-professional training in the practice of preventive medicine. The following are just a few examples of things that can be done now. For example, we now have the authority to clean the polluted air over most of the major urban areas of this country.
>
> "Other approaches include new methods of paying for and organizing health services. We, at present, invest huge sums in medical care through public and private support. The same means of coverage, however, such as Title XVIII, do not provide for 'health protection': There is no payment for periodic health appraisal on an out-of-hospital basis, with provision for follow-up care. This should include individual and group counseling services necessary for health maintenance, given by a physician or other health professional."

The Magnuson group said that "despite the convincing case for prevention, about two-thirds of all medical schools do not have departments of preventive medicine. This lack is appalling. We should at once encourage the establishment, or strengthening, of these departments in all medical schools, and emphasize a more realistic training program for the physicians of tomorrow."

* * * * * * * * *

The 1968 supplemental report on Smoking and Health by the Surgeon General of the Public Health Service reaffirmed that cigarette smoking is a health hazard.

The report was sent to Congress the same day as a Federal Trade Commission recommendation that cigarette advertising be banned from television and radio.

Highlights of the smoking report were:

- New evidence indicating that the life expectancy among young men is reduced by an average of eight years in "heavy" cigarette smokers, ie. those smoking over two packs a day, and an average of four years in "light" cigarette smokers, those smoking less than one-half pack per day.
- Cigarette smoking can contribute to the development of cardiovascular disease and particularly to death from coronary heart disease. Some of the harmful cardiovascular

effects appear to be reversible after cessation of cigarette smoking.

- New evidence that the previous finding that cigarette smoking is the most important cause of chronic bronchopulmonary disease in the United States.
- Additional evidence that cigarette smoking is the main cause of lung cancer in men and is causally related to lung cancer in women.

* * * * * * * * *

Robert Q. Marston, MD, was appointed to succeed **James A. Shannon, MD,** as Director of the National Institutes of Health, effective Sept. 1.

Since April 1 Dr. Marston, 45, has been administrator of the NIH's Health Services and Mental Health Administration. He joined NIH in 1966 as the first administrator of the Heart Disease, Cancer and Stroke Regional Medical Programs. Before that, he had been vice chancellor and dean of the University of Mississippi Medical School.

Dr. Marston, in accepting his new post, listed knowledge first then money and manpower as the key factors in future improvements in the health of Americans.

"The ultimate constraint of our ability to effect the health of the people is neither dollars nor manpower, but the knowledge gained through research," he said.

"A major problem of the future will be to insure institutional stability during times of manpower and fiscal shortages on which future (medical research) success is dependent."

In appointing Dr. Marston, **President Johnson** said the new NIH director faces a "staggering job" because not only the United States, but the entire world needs "rescue from death and disability that medical research promises."

The President expressed the hope that Dr. Marston's leadership in research would play an important role in an effort to reduce the death rate from serious diseases by 10% by 1976.

* * * * * * * * *

The John E. Fogarty International Center for Advanced Study in the Health Sciences has been established in memory of the late Rhode Island congressman who was a leader in health legislation for many years. Congress provided an initial appropriation of $500,000 for the new center to start operation in the National Institutes of Health until its own building is completed. The center's first director is **Milo D. Leavitt, Jr., MD,** former director of the NIH Office of Program Planning.

* * * * * * * * *

U.S. Attorney General Ramsey Clark appealed for broad support and cooperation of the public in enforcement of the laws against marijuana and LSD. Otherwise, he said, the law cannot be enforced effectively. Enforcement must be accompanied by research and education, he said. "The youth of today are extremely sophisticated about drugs, and they are also highly selective of the wave lengths they tune in on—the channels of information they select."

* * * * * * * * *

President Johnson named a special committee to develop a five-year program for providing more effective birth control. The study committee will be headed by HEW Secretary **Wilbur J. Cohen. Mrs. John D. Rockefeller, III,** of New York, will serve as his co-chairman. An official said one matter to be studied would be the fact that present methods of contraception are not adequate. He said the so-called "pill" is too expensive for widespread use in some areas and it is difficult to educate illiterate people in its use.

The National Institutes of Health has asked processors of whole pooled human blood plasma to halt its interstate shipment because the substance has been causing hepatitis, an infection of the liver, in one out of ten patients receiving transfusions. The move is expected to halt use of most such plasma of which about 300,000 pints are given annually to about 100,000 patients in the United States. The agency acted on a report issued in April by the National Research Council saying use of whole pooled plasma should be discouraged and even discontinued because of the hepatitis danger.

* * * * * * * * *

The Senate Health Subcommittee was told that the nation talks more and does less about its five-million alcoholics than any of its other health problems. **Michael Gorman,** a spokesman for the National Council on Alcoholism, said that the losses from alcoholism are now running about $2 billion a year. **Philip R. Lee, MD,** Health, Education and Welfare Assistant Secretary, supported Gorman's statement. According to Dr. Lee, alcoholism is an "enormous economic liability to the nation" in terms of job absenteeism, lowered productivity, and medical insurance expenses.

Montgomery County Medical Society

A testimonial dinner was given for Frank Broschart, MD, at the Washingtonian Golf & Country Club on June 27, in honor of his 50 years in medical practice. The dinner was sponsored by the Gaithersburg Chamber of Commerce and was well attended by the town citizens.

Marvin I. Mones, MD, made the presentation of an oil portrait of Dr. Broschart to Mrs. Broschart.

Presentations to Dr. Broschart included distinguished service certificates.

Dr. Broschart graduated from the old Baltimore Medical College in 1911, which later became a part of the University of Maryland Medical School. He was President of the Maryland-Virginia-D. C. Medical Society, and is a Past-President of the Montgomery County Medical Society.



DR. BROSCHART



DR. ALLEN

In Memorium

Samuel Allen, MD, General Practitioner, died July 1, 1968. He resided at 10407 Fawcett Street, Kensington, and is survived by his wife and three children; two daughters and one son.

A native of Toronto, Ohio, Dr. Allen graduated from Ohio State Medical School and Ohio State University where he obtained his medical degree in 1939. Dr. Allen's internship was served at Montifiore Hospital, Pittsburgh, Pa., and his residency at Walter Reed Army Hospital. Dr. Allen began his private practice in 1946.

Baltimore County Medical Society

On August 21, the Baltimore County Medical Association held its 22nd Annual Crab Feast at Duffy's Tavern on Frederick Avenue. Members and their wives enjoyed crabs served in many different ways.

During the business meeting, the Medical and Chirurgical Faculty's Recommended Changes in the Medical Practices Act was voted on by the members and accepted.

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(1) Bilbao, M. K.; Frische, L. H.; Rösch, J., and Dotter, C. T.: Hypotonic Duodenography, Scientific Exhibit, Radiological Society of North America, Chicago, Nov. 27–Dec. 2, 1966.

(2) Bilbao, M. K.; Frische, L. H.; Dotter, C. T., and Rösch, J.: Hypotonic Duodenography, Radiology *89*:438-443 (Sept.) 1967.

See also: Liotta, D.: Pour le diagnostic des tumeurs du pancréas: La duodénographie hypotonique, Lyon chir. *50*:445-460 (May-June) 1955.

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In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

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In addition to its primary indications for duodenal and gastric ulcer, Robinul Forte (glycopyrrolate) is indicated for other G-I conditions that may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

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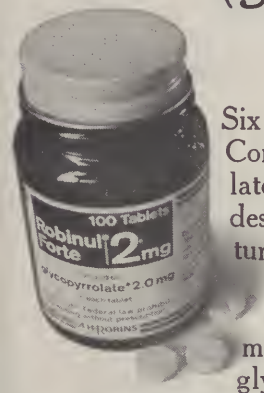
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Dosage: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day; in the a.m., early p.m., and at bedtime. See product literature for full prescribing information. Supply: Robinul (glycopyrrolate 1 mg.): Robinul Forte (glycopyrrolate 2 mg.): Robinul-PH (glycopyrrolate 1 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming); Robinul-PH Forte (glycopyrrolate 2 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming), in bottles of 100 and 500 tablets. A. H. Robins Company, Richmond, Va. 23220.

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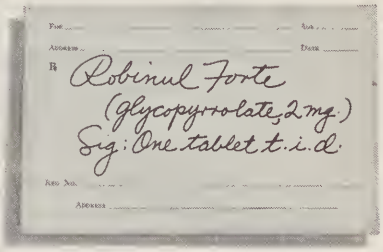
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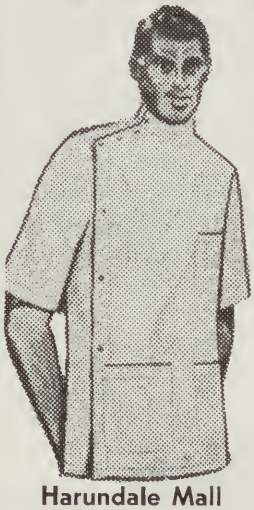
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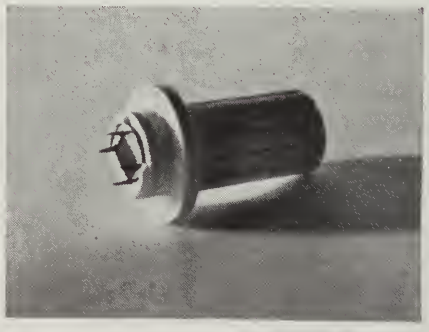
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Hemo-therapy has become multiphasic. The day is past when the blood bank existed only for the crossmatching of red cells. With the need for components and special products from blood, there is an increasing demand for the substrate with which to work. There are now 180-million people or better in the United States and approximately six-million units of blood are collected each year; therefore, around 3% of the population donates blood that is used each year.

Survey of Blood Use In Baltimore

EDWARD E. MORSE, MD
Medical Director
Baltimore Regional Red Cross Blood Program

Where does this blood come from? A phenomenon that has occurred in The Johns Hopkins Hospital parallels the experience in the nation at large. In the 1950's most of the blood was provided by donors who walked into the hospital blood bank: volunteer donors, friends, relatives of the patient in the hospital. Blood assurance programs and blood insurance programs developed in the late 1950's. About one-third of the blood coming into this hospital after 1959 was supplied by the Red Cross Blood Assurance Program, and the volunteer donors that came into the blood bank itself decreased. As special needs arose, such as open-heart surgery requiring large amounts of blood, freshly drawn on the day of surgery, or plasma products for patients with hemophilia, the demands on the existing blood supply were of such a specialized nature that a number of donors were paid for giving their blood. They might be called in the night for exchange transfusions for a baby or they might be required to come in at six-thirty or seven o'clock in the morning, in order to supply blood for open-heart surgery.

As the special needs grew, it became necessary to purchase a great deal of blood from a commercial blood source. The supply from this source has increased over the middle 1960's to the point where most of the blood is coming from donors who are paid, and a relatively small portion from donors who are relatives and friends of the patients. It is important to point out that the total number of units of blood that are used in this particular hospital have not increased although the need for special components obviously have. This pattern of blood supply has been paralleled by many hospitals in this community and by many hospitals in the entire country. The supply is not adequate.

There are two alternatives. One is a better inventory control. In a one-month survey of the blood that was utilized by the Surgical Service at The Johns Hopkins Hospital, we found that of 919 patients that underwent a surgical procedure that required general anesthesia and incision, a little over half had blood requested from the blood bank. It was set up in advance and held for a period of time following the surgery. Of the patients who had blood crossmatched, one in four actually used the blood (113 out of 492). Ana-

lyzing the data a little further, when one unit was requested seven patients actually used blood but 71 had blood crossmatched. When two units were requested, 42 patients out of 301 used blood and so forth. When the surgeon feels sure enough that he is going to need to use blood that he requests three, four or more units, then the likelihood of his using the blood increases. The surgeons are really a great deal better at keeping the blood in the blood vessels than they think they are, and perhaps we are setting blood aside that might be used for a patient who is actively bleeding. The other alternative is to make better use of the blood we already collect. The following data comes from the Red Cross in Baltimore. Distribution of blood and its products in the Baltimore area by the Red Cross last year included 23,000 units of whole blood to the 32 area hospitals. Four-thousand more units were sent to government hospitals including the Public Health Hospital, V.A. Hospitals and other Red Cross Centers. There were 3,521 units put into plasma pools for albumin, gamma globulin and similar products, and 1,176 units put into fresh-frozen plasma. While the Red Cross Program, here in Baltimore, supplied small amounts of various blood components, the vast majority of blood distributed to hospitals was distributed as whole blood.

Fresh-frozen plasma was produced from 1963 on, the number of outdated red cells on the shelves of the Red Cross Blood Bank has paralleled the increasing production of fresh-frozen plasma. Utilization of the concentrated blood cells became the major obstacle to component therapy. There is an apparent reluctance to use concentrated red cells. (Our preference is to call them concentrated red cells rather than packed cells, because they are not really packed.) The concentrated red cells seldom have a hematocrit more than 65 to 70. It is simply a lack of knowledge in this area, and a lack of motivation to use this blood product that concerns us in the area of component therapy.



The Blood Research Laboratory at the Naval Hospital, Chelsea, Massachusetts has been officially designated as the Navy's test and evaluation center for blood and blood products, by the United States Navy's Bureau of Medicine and Surgery. Over the past six years this laboratory has studied several methods for both liquid- and freeze-preservation of human red cells. Our primary interest has been in determining the clinical efficacy of separated red cells, either liquid-stored or previously-frozen. Although separated red cells have been called "packed" red cells by some, concentrated red cells is a more accurate term.

Clinical Effectiveness of Concentrated Liquid Stored Red Cells and Previously Frozen Red Cells*

C. ROBERT VALERI, LCDR, MC, USNR
Officer In Charge
Naval Blood Research Laboratory
Naval Hospital
Chelsea, Massachusetts

For the past year the Chelsea laboratory has been evaluating separated red cells prepared from ACD blood (whole blood collected in acid-citrate-dextrose solution—ACD, National Institutes of Health, Formula A). The ACD blood was collected in double packs, at various naval hospitals in the United States, and transported in wet ice (at +4 C) to Chelsea, Massachusetts. Within three to four days after collection and storage at +4 C, the red cells in each of 46 units were sedimented in a PR-2 refrigerated centrifuge** at 3500 RPM for seven minutes.

From each of 30 units most of the visible plasma was expressed into an attached transfer pack, so that the hematocrit of the concentrated red cells was approximately 60 to 65%, and approximately 100 ml of plasma remained in the unit. With each of the other 16 units of blood, all of the visible plasma was removed, so that the hematocrit of the concentrated red cells was approximately 75 to 80%, and approximately 30 ml of plasma remained in the unit. Prior to transfusion, approximately 150 cc of non-buffered saline was added to each unit, stored as separated red cells with hematocrit of approximately 80%, in order to reduce the viscosity and permit the more rapid infusion of these cells. The separated red cells stored at hematocrits of approximately 60 to 65% could be transfused without the addition of saline.

The mean length of storage at +4 C of the concentrated red cells was approximately 23 days,

* This work was supported by the U. S. Navy.

The opinions or assertions contained herein are those of the author, and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at large.

** International Equipment Company, Needham, Massachusetts.

with a range of 14 to 29 days.

In these studies the post-transfusion survival of the separated red cells was measured using an automated differential agglutination technic.[1, 2] This technic permits the simultaneous measurement of two red cell populations in the same recipient. The ABO and Rh systems were used in the separation of donor from recipient red cells.

Transfusions of both group-specific (compatible in major and minor crossmatch) and "universal donor" group O blood (incompatible in minor crossmatch) were studied. The effects which residual incompatible plasma (accompanying the transfused compatible, separated red cells) had on recipient red cells were compared to the effects produced by residual compatible plasma. In theory, transfusion of incompatible plasma might be expected to adversely affect the survival of the recipient's own red cells, with consequent improvement in apparent survival of donor red cells.

The immediate post-transfusion survivals of concentrated red cells accompanied by either compatible or incompatible plasma, after storage at +4 C for approximately 21 days, averaged 92 and 94% respectively. The 24-hour post-transfusion survival for the red cells with compatible plasma was 77.3% compared to 81.9% for the red cells with incompatible plasma. These differences are not statistically significant ($p > 0.05$). Hence, the simple procedure of removing supernatant plasma containing incompatible isoagglutinins effectively prevents significant destruction of recipient red cells following transfusion.

The effects of no visible plasma (hematocrit approximately 80%) or of a small amount of visible plasma (hematocrit approximately 60-65%) on the storage of concentrated red cells at +4 C for up to 22 days was also investigated. The mean 24-hour survivals for concentrated red cells stored at hematocrits of either 80% or 60% were 78% ± 6.8 and 80.4% ± 6.7 respectively. The amount of plasma remaining with the separated red cells (30 cc compared to 100 cc) had no significant effect on their subsequent survival *in vivo*.

The *in vivo* survivals of red cells stored as whole blood or as concentrated red cells have been evaluated in the same recipient. An anemic patient (Group A, Rh-positive) suffering from disseminated lupus erythematosis was transfused simultaneously with O-negative whole blood and with O-positive concentrated red cells (hematocrit of approximately 60%), both stored at +4 C for 23 days. The recovery and survival characteristics of the two red cell populations were similar. In these transfusions the patient received approximately 400 cc of incompatible plasma and the amount of anti-A isoagglutinins present did not adversely effect the survival of the recipient's chromium labeled red cells ($T\frac{1}{2}$ 26.9 days). Similarly, an anemic patient (B-positive) suffering from traumatic injuries was transfused with both O-negative concentrated red cells (stored with a hematocrit of approximately 80% at +4 C for 23 days and resuspended with 150 cc of buffered saline at the time of transfusion) and O-positive whole blood stored at +4 C for 21 days. Again, *in vivo* survival of the two red cell populations was similar. The volume of isoagglutinin anti-B infused in this study (approximately 300 cc of incompatible plasma) had no adverse effect on the recipient red cell survival measured by chromium ^{51} ($T\frac{1}{2}$ 29.4 days).

The 24-hour survivals of concentrated red cells stored for 20.2 ± 1.2 days and 23.6 ± 2.0 days were not significantly different from the mean 24-hour survival of whole blood stored for 19.7 ± 1.2 days.

These results demonstrate the clinical efficacy of concentrated red cells and support a program for collection and utilization of the various blood components. The data indicate that whole blood can be collected and the blood components separated and preserved individually as platelets, anti-hemophilic globulin (AHG), or fresh frozen plasma and/or used for plasma protein fractionation. The separated concentrated red cells can then be stored at +23 days in either one-third of the original plasma volume or in minimal amounts of plasma, with *in vivo* survival comparable to that of whole blood. Moreover, removal of plasma in the preparation of concentrated red cells for the blood components significantly reduces the titers of the isoagglutinins anti-A and anti-B. Therefore, the concentrated O-negative red cells may be used as universal donor units.

In this regard, the present need for low-titer, O-negative blood for Vietnam is difficult to satisfy, because low-titered blood is not easily found. The immunization of healthy servicemen with plague, influenza, and other vaccines in preparation for travel in Southeast Asia has been associated with potent stimulation of anti-A isoagglutinin titers. Therefore, the removal of plasma may help provide low-titered, O-negative blood.

Freeze-Preservation of Human Red Cells

It should be emphasized that "frozen blood" usually refers to previously frozen red cells, and not whole blood as ordinarily thought of in the blood bank. Current methods of freeze-preservation of human red cells necessitate post-thaw washing and the biologic product is essentially concentrated red cells.

It should be recognized that the grand expectation in red cell preservation by freezing has been a biologic product for transfusion, that, after thawing, would require no additional processing. This ideal, one-step approach would eliminate the necessity for post-thaw processing, and represents a desideratum in terms of technologic simplification and minimization of the time and effort required to prepare the red cells for transfusion. In practice this ideal has yet to be realized.

The Chelsea laboratory has had no experience with the one-step approach. The recent contribution of Gikas et al [3] using hydroxyethyl starch and the rapid-freeze approach with liquid nitrogen is extremely encouraging.

Current methods for processing frozen red cells utilize the additive glycerol, either in high concentration in combination with the slow freeze-thaw technic, or in low concentration with the rapid freeze-thaw technic. The use of the intracellular cryoprotective agent, glycerol, necessitates post-thaw washing to reduce the intracellular glycerol concentration to about 2%, otherwise hemolysis of the preserved red cells will occur following transfusion. The removal of glycerol represents the major technological problem and the acceptable glycerol concentration following washing is less than 1%. Post-thaw washing is now accomplished by various continuous centrifugation processes, or by serial centrifugation ("batch washing"), or, alternatively, by a dilutional process with recovery of the red cells by agglomeration.

One major approach to freeze preservation of red cells utilizes a high concentration of glycerol (approximately 40% weight per volume) and the slow freeze-thaw technic, with storage at —80 C (temperature of dry ice and alcohol). This is the method introduced by Audrey Smith [4] and Mollison et al,[5] and it has been extensively evaluated by Haynes et al.[6] The second major approach uses a low concentration of glycerol (approximately 20% weight per volume) plus a rapid freeze-thaw technic with liquid nitrogen. This approach was introduced by Pert [7] and has been clinically evaluated initially by Krijnen et al [8] and more recently by Rowe.[9]

The original continuous centrifugation principle using the Cohn Blood Fractionator, as introduced by Haynes et al,[6] to add to and remove high concentration glycerol (40% weight per volume) from red cells frozen and stored at —80 C is cumbersome, awkward, and impractical for widespread clinical use. This method has been recently modified to achieve washing efficiency and simplicity. A major advance has been achieved by the introduction of the stainless steel and polycarbonate ADL (Arthur D. Little) reusable bowls, which can be attached to a number of commonly available refrigerated centrifuges by using a special drive chuck attachment. Although the reusable ADL bowls represent a marked improvement on the original Cohn Blood Fractionator, the urgent need is for disposable bowls to obviate the time-consuming and costly steps involved in dis-assembling, cleaning, re-assembling and sterilization of the permanent bowls.

In 1963, Huggins introduced a novel approach for removing dimethylsulfoxide, a penetrating additive, from volumes of red cells that had been slowly frozen to —85 C, and then slowly thawed.[10] This technic of so called "reversible agglomeration" achieves the removal of the additive with large volumes of a non-electrolyte solution. In the low ionic strength of the resulting environment, red cells are recovered through the phenomenon of spontaneous clumping. The agglomerated red cells can be disaggregated by the addition of electrolyte solutions. Because of the uncertain toxicity of dimethylsulfoxide, Huggins later modified his method by substituting the non-toxic, penetrating additive, glycerol, in the freezing step.[11]

With high concentration of glycerol (40 to 50% weight per volume), as required to protect slowly frozen and thawed red cells, a large volume (approximately 4 to 6 liters) of wash solution and a considerable amount of time (approximately one hour) are consumed in washing the thawed cells. To overcome these difficulties, Pert et al have recommended a method for preserving red cells in the presence of low concentration of glycerol (14 to 16% weight per volume) by controlling the rate of freezing with liquid nitrogen.[7] The thawed red cells can be washed by a serial centrifugal technique (batch wash), or by a continuous centrifugation technique with either sorbitol, sucrose or mannitol in the wash solution.

The washing can be performed in routine laboratory centrifuges (serial batch washing), or in special red cell washing machines such as the ADL bowls, and other developmental systems using continuous centrifugation.

Since the current methods of freeze-preservation of human red cells requires post-thaw washing, of obvious importance in the evaluation of the washing procedure are the volume of wash and the time necessary to remove the intracellular additive from a unit of clinically acceptable previously-frozen red cells. Equally important are the quality and quantity of the ultimate red cell product: that is, the *in vitro* recovery of red cells, amount of supernatant hemoglobin in the unit, and the *in vivo* survival of the preserved red cells.

The Chelsea laboratory is presently investigating optimum conditions for washing both high and low-concentration glycerolized red cells. High-concentration (approximately 40%) glycerolized red cells can be washed successfully with a gradient electrolyte cycle in the reusable ADL bowl and stored for 24-hours post thaw, with good post-transfusion survival. Using the ADL washing geometry, one can reduce the high glycerol concentration to less than 1% in approximately 35 minutes. By contrast, the washing of low-concentration (approximately 20%) glycerolized red cells can be accomplished within seven to ten minutes. Because the movement of glycerol across the red cell membrane is so rapid, the removal of glycerol from thawed red cells is basically limited by the efficiency of the washing device in reducing the extracellular glycerol concentration.

Clinical Experience with Frozen Blood

In January 1966, at the request of the Department of Defense, the U. S. Navy Bureau of Medicine and Surgery established frozen blood facilities in Vietnam, to evaluate the practicability of a supply of frozen blood in a combat area as a supplement to liquid blood preserved in ACD. Because of the "relative simplicity" of the agglomeration process and the encouraging results obtained with both autologous and homologous transfusions, the Huggins method was selected for evaluation in this study. Mobile blood processing units, capable of storing frozen red cells at —80 C and deglycerolizing these cells with the Huggins Cytoglomerator, were established aboard the hospital ship USS Repose and at Danang, South Vietnam.

Approximately 500 units of selected red cells (O cde/cde, K^-, Fya^-, and O CDe/CDe, K^-, Fya^-) were glycerolized in the presence of 0.3% Na_2 EDTA within five days of collection in ACD (NIH, Formula A). The addition of Na_2 EDTA is required to prevent irreversible binding of B_1C globulin to red cells exposed to low ionic medium during glycerolization, as occurs in the Huggins technic. The glycerolized red cells were then stored at —80 C, and shipped in containers of polystyrene foam with dry ice to Danang, South Vietnam, and to the USS Repose, stationed off South Vietnam, via Oakland, California, which has —80 C refrigeration and dry ice.

Within six months, from January to July 1966, 43 critically wounded servicemen requiring massive transfusions received a total of 347 units of ACD blood and 307 units of frozen blood at Danang. The *in vitro* loss related to processing of frozen units was 26.7%. No significant post-transfusion differences were noted between patients receiving either frozen red cells or ACD blood, with reference to elevations of plasma hemoglobin or bilirubin, platelet counts, urine hemoglobin, or serum creatinine. For neither the frozen nor the ACD-preserved red cells was removal of the compatible, non-viable red cells associated with hemoglobinemia.

None of the patients observed in the study developed acute renal failure, despite the massive nature of many of the injuries. Twenty of the most severely injured were transfused with an average of 30 units of a combination of ACD and previously frozen red cells. The highest serum creatinine was 1.9gm% in a patient who received a total of 91 units of blood, 41 of which were frozen. The creatinine observations indicate that renal insufficiency was infrequently seen in the badly injured recipient. Renal function in traumatic shock depends upon a number of variables, including location and extent of injury, magnitude and duration of shock, adequacy of fluid therapy, and quality of the transfused cells. The fact that renal insufficiency was not seen frequently in the study is probably the result of the shortened evacuation time and improved resuscitative techniques in general. Resuscitation was initiated with large volumes (5-10 liters) of balanced salt solutions (lactated-Ringer's solution), together with mannitol and sodium bicarbonate. The large volumes of crystalloids used in the initial resuscitation of these wounded servicemen were followed by previously-frozen red cells administered as concentrated red cells (hematocrit of approximately 70%).

A decline in recipient platelet count (secondary to depletional and dilutional phenomena) was observed following the transfusion of large volumes of either ACD or previously-frozen red cells. Since stored ACD blood, like the frozen blood, contains no viable platelets, the degree of thrombocytopenia observed in recipients was similar whether ACD blood or frozen red cells were administered.

Hemoglobinuria was observed following the multiple transfusions of previously-frozen red cells, because of the amount and state of supernatant hemoglobin in each unit. The supernatant hemoglobin in the Huggins-processed blood is solely in the free state, since no protein is available in the supernatant medium for hemoglobin binding. Hence, following the transfusion of multiple units of frozen blood, recipient hemoglobin-binding capacity and tubular-reabsorption capacity were exceeded and hemoglobinuria occurred. In this study, there was no significant correlation between hemoglobinuria and renal insufficiency (as determined by serum creatinine of greater than 1.5gm% over the seven to ten days following transfusion). The failure to demonstrate a correlation between hemoglobinuria and renal insufficiency may be related to initial vigorous resuscitation with balanced salt solution, and the prompt administration of mannitol.

Neither hemolytic nor non-hemolytic transfusion reactions were noted with the administration of frozen red cells. In eight patients, not included in this study and transfused with ACD blood, hemolytic and non-hemolytic transfusion reactions were observed. The hemolytic transfusion reactions were caused by (1) the passive transfer of anti-A and anti-B isoagglutinins to group A and B recipients receiving group O blood, and (2) the administration of Rh-positive red cells to previously sensitized Rh-negative recipients.

It must again be stressed that the frozen blood is essentially concentrated red cells. If coagulation factors are needed, AB fresh frozen plasma should be available. If the need is for whole blood, a volume expander can be given with every two units of these concentrated red cells. In case of thrombocytopenia, fresh blood or platelet concentrates should be administered.

These initial observations on the operation of a frozen-blood bank system in a combat zone have demonstrated both clinical acceptability and technical feasibility. It should be obvious, however, that frozen blood is merely supplementary to the ACD, liquid preservative program.

Because of clinical studies that showed frozen red cells to be safe and effective, the U. S. Navy has also established a frozen blood bank at Clark Air Force Base Hospital, Clark Field, Philippine Islands, to provide selected red cells for uremic patients undergoing hemodialysis. In addition, a bank for frozen blood has been installed aboard the USS Sanctuary, which is also supporting the military forces of the United States in South Vietnam. To supply these sites in Southeast Asia with frozen red cells, donor blood banks have been organized at the Naval Medical School, Bethesda, Maryland, and at the Oakland Naval Hospital, Oakland, California, for the procurement and freezing of the selected red cells.

Multiple units of concentrated, previously frozen red cells, processed by the Huggins technic, have also been clinically evaluated for extracorporeal circulation by Bougas et al [12] at the University Hospital, Boston, Massachusetts. These red cells have been diluted with lactated Ringer's solution and albumisol in priming the pump. There were no significant differences in morbidity and mortality in recipients receiving either ACD red cells stored for up to five days at +4 C, or previously frozen red cells processed by the Huggins technic. Coagulation studies, renal function parameters, and hematologic measurements have likewise shown no significant differences in two groups undergoing open-heart surgery (one receiving the ACD-stored red cells and the other receiving primarily previously-frozen red cells).

A recent study at Chelsea Naval Hospital demonstrated the further usefulness of freeze-preservation in providing autologous red cells for obstetrical and gynecological patients who required blood transfusions during elective surgical operations. Two units of autologous red cells were collected and frozen in the two-month period prior to the surgical procedure, and the previously-frozen red cells were resuspended in autologous plasma on the day of the elective surgery.

Freeze-preservation of autologous red cells incidentally prevents the two major risks of homologous transfusion—transmission of serum hepatitis and blood group iso-sensitization. Results of the present freeze-preservation technics, which require post-thaw washing, suggest that the incidence of post-transfusion hepatitis may be significantly reduced in homologous transfusions. This reduction in post-transfusion hepatitis probably reflects the effectiveness of the washing pro-

cedure, which requires from 4 to 6.7 liters of solution.

At the present time, over 3,000 units of previously-frozen red cells (transfused as concentrated red cells in a non-plasma-containing medium) have been administered variously to stable medical recipients, severely injured combat casualties, in elective surgical procedures, in hemodialysis for uremia, and via extracorporeal circulation. The good results have shown these concentrated, previously-frozen red cells to be safe and efficacious.

It should be stressed that an ideal system for the freeze-preservation of red cells does not exist. The major problems with the Huggins method are the excessive *in vitro* loss (approximately 25%), the 6.7 liters of wash solution necessary per unit of red cells, and the one hour required for preparation of one to five units.

Summarizing, recent data in our laboratory indicate that a biologic product of frozen red cells can be prepared to meet the following criteria:

- ***In vitro* recovery of 90% or more of the red cells.**
- ***In vivo* survival comparable to that of ACD red cells stored at +4 C for one week.**
- **Total supernatant hemoglobin in one unit of less than 200 mg.**
- **Processing time of 30 minutes or less to prepare the frozen red cells for transfusion.**
- **Volume of wash solution not in excess of three liters.**

At the present time the only obstacle to providing such a biologic product of frozen red cells is disposable blood containers and processing "software" to carry out simple, automated washing procedures.

In conclusion, the data presented show the clinical effectiveness of concentrated, liquid-stored red cells and previously-frozen red cells. The use of concentrated red cells, either liquid-stored or previously-frozen, permits the collection, separation, and storage of a variety of blood components. This approach will permit the intelligent use of blood and blood products and thus provide the best medical care of individual patients and the community.

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Current Concepts in the Use of Whole Blood in the Management of Hemorrhagic Shock

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Like many things in medicine, enthusiasm for the relative use of whole blood in shock has swung back and forth like a pendulum. Many of us were brought up in the days of liberal transfusion, when blood was thought to be a good general tonic to hasten wound healing or shorten convalescence. In those days, it was common to see transfusion begun in the operating room even before the incision, and in the early post-operative period, if the patient's blood pressure declined, it was often simply assumed that either there had been more blood lost than estimated or that there had been continued oozing from the operative site. The standard "opening gambit" in such a situation was to give a unit or two of blood and await further developments before undertaking a full scale diagnostic investigation of other causes of post-operative hypotension. In those days, a surgeon might have summarily dismissed this topic with the cliché, "Nothing replaces lost blood better than blood itself".

Since that time, many things have changed, including our attitudes about shock. The emphasis has shifted from the hemodynamic to the metabolic, and from the macrocirculation to the microcirculation. The essence of shock is no longer considered to be inadequate blood pressure, but rather inadequate tissue perfusion. Thus in managing the patient in shock, today's house staff no longer leans solely on the blood pressure, but is equally concerned with the central venous pressure and urinary output.

So too, have our ideas about blood transfusions changed. The desire to avoid unnecessary exposure to the risks of homologous blood transfusion has gained command so that we find ourselves in an era where the single blood transfusion is severely chastised and some are even advocating the practice of the surgical patient serving as his own donor, that is, autologous transfusion with blood drawn a few weeks prior to elective surgery. We also find now, that the once simple stand of replacing lost blood pint-for-pint has not only been weakened and eroded but, in some areas at least, has been literally washed away in a veritable tidal wave of lactated Ringer's solution.

The ground swells for this trend may be found in the 50's when Wilson reported a large series of consecutive gastrectomies in which lost blood was successfully replaced by intravenous saline alone, and Rosenthal successfully managed a significant number of major burns in South America without using either blood or plasma but electrolyte solutions. These were the first of a number of clinical experiences which challenged two time-honored concepts: 1) that saline solutions could only incompletely or transiently restore blood volume, and 2) that salt solutions were undesirable during, or immediately after, operations or trauma, because of the tendency toward abnormal salt and water retention during the post-traumatic period. Next came several independent laboratory studies which showed, in standard canine hemorrhagic shock preparations, that balanced salt solutions, if given in sufficient volume, resulted in a lower mortality than simple replacement of the shed blood alone.

This heretical approach to the resuscitation of shock was given extensive clinical trial at Parkland Hospital in Dallas where large volumes of lactated Ringer's solution were used in the resuscitation of numerous cases of extensive trauma. The explanation for the success of this approach has been offered by the triple isotope studies of Shires, in which he labeled the red cell mass with C^{51}, the plasma volume with I^{131} and the extracellular fluid space (ECF) with $Na_2{}^{35}SO_4$ and demonstrated that in the larger, *shocking* hemorrhages there is a considerable ECF loss over and above that which might be expected from the actual amount of blood lost. Although skepticism over the validity of these findings still exists, proponents of this approach can cite numerous animal experiments showing that buffered saline given in a three or four to one ratio to the volume of blood lost is empirically more effective than simple volume replacement with blood or colloid. Ben Rush, in an attempt to clarify this controversy of colloid versus crystalloid replacement, showed that buffered saline in a four to one ratio was as effective as dextran in resuscitating dogs after *shocking* degrees of hemorrhage, but was inferior to dextran in replacing large (65%) blood volume losses when given immediately so that hypotension was prevented.

Finally, the significance of the ECF losses associated with shocking degrees of hemorrhage has been further supported by recent work from the University of Buffalo using quite a different approach, namely, monitoring interstitial fluid pressure. After bleeding dogs to between 30 and 50 mmHg pressure for 135 minutes, replacement of the shed blood restored blood pressure and central venous pressure to normal but not the interstitial fluid pressure. An additional infusion of lactated Ringer's solution (5% of body weight) one-half hour later restored interstitial fluid pressure in one group, but in another group in which an equal volume of dextran was administered after the same interval, the interstitial fluid pressure either did not return to normal or became lowered still further.

Of course, it was inevitable that we would finally overextend the limitations of the use of this "Texas Blood." This could have been predicted from experimental reports. In the same experiment cited above, Rush also demonstrated the limitations of replacing lost blood with buffered saline at a four to one ratio in a series of graded hemorrhages, with mortality resulting after exceeding 50% blood volume replacement. In addition, there have been some unfortunate clinical experiences when enthusiasm for resuscitation with crystalloid solutions has been carried to extremes. Probably the most publicized of these has been the experience of one of the medical units in Vietnam which instituted a policy of relying mainly on buffered saline solutions for the initial resuscitation of all casualties. They observed a gratifying hemodynamic response with a rapid return of urinary output and avoidance of renal shut down. Although the usual cases received something like five liters of buffered saline followed by five units of blood within the first 24 hours, some of the more severe cases received as much as 15 liters or more of Ringer's lactate during the initial period of resuscitation. Unfortunately a number of these died of pulmonary insufficiency with consolidated, edematous, noncompliant lungs. This complication has been blamed, though without proof as yet, on a combination of lowered oncotic pressure and elevated left atrial pressure secondary to over-infusion with crystalloid solutions.

Instances have also been sporadically reported from civilian practice, and recently, a joint plea was published by Francis Moore and Tom Shires calling for moderation in the practice of restoring blood losses with electrolyte solutions. So the pendulum is swinging back. Current feelings regarding the use of crystalloid solutions in blood volume replacement which greatly effects the rela-

tive use of whole blood in the treatment of hemorrhagic shock are summarized as follows:

- Ringer's lactate or buffered saline has proved itself sufficiently effective in emergency blood volume replacement, to gain enough time for proper typing and crossmatching, without penalty, in all but the most overwhelming cases of hemorrhagic shock.
- We now recognize that there are significant losses of ECF associated with shocking degrees of hemorrhage that should be concomitantly restored. This should spare blood that was formerly administered in the situation where apparently adequate replacement of blood losses failed to sustain the patient's pressure.
- The policy of giving lactated Ringer's solution prior to the replacement of lost blood probably results in better maintenance of renal function. Indeed, the incidence of renal failure in Vietnam appears to be significantly less than in Korea although other factors, such as the more rapid transportation of the wounded to a medical facility, must be taken into consideration.
- In addition, the initial use of lactated Ringer's solution in resuscitation would appear to provide better buffering against acidosis, less bleeding problems and less problems with subsequent crossmatching than such plasma substitutes as dextran.
- Finally, we must realize, in spite of these several advantages to the use of lactated Ringer's solution in early resuscitation, beyond a certain point one is simply maintaining effective circulating volume by filling, or rather overfilling, the vascular and extracellular spaces at a faster rate than it can leak out, a practice that carried definite risks, particularly to the lungs. It is beyond this point that there is indeed "no substitute for lost blood like blood itself".

Summary

As far as translating these concepts into practical, clinical terms, in the management of a patient with sudden unexpected massive hemorrhage, begin with infusions of lactated Ringer's solution—rapidly enough to restore arterial and central pressure and urinary flow. If necessary, give up to about two or three liters of this, followed or accompanied by two units of stored plasma, plasmanate, hydroxyethyl starch or dextran (in that order of preference). Then, if the situation does not stabilize enough to wait for completely crossmatched blood, use either low titer O or type-specific blood rather than continue indefinitely with electrolyte solutions or plasma substitutes. In most cases of serious bleeding, one should be on the way to the operating room by this time.

In addition, for every three to four units of blood replaced in the *shocked* patient, give a liter of balanced salt solution. Experimentally, we have been guilty of comparing replacement with blood with replacement with crystalloid solutions. Only recently has Baue shown what one would suspect; namely, that the combination of the two is better than either alone.

As far as other additives in massive blood replacement, calcium rarely need be given. The risk of ventricular fibrillation is more significant than the risk of citrate toxicity. It is advisable to use some method of warming the blood, if possible, whenever multiple, rapid transfusions are being given. This appears to significantly reduce the incidence of cardiac arrest in this situation. In addition, if one does not want to give additional volumes of buffered salt solution (as in the bleeding patient not in shock, or the cardiac) add instead an ampule of sodium bicarbonate ($NaHCO_3$) for every three to four units of blood. Howland has shown that the combination of warming the blood and adding bicarbonate to it has reduced the mortality in massive blood replacement from 40 to 8%.

Although open-heart surgery using cardiopulmonary bypass has been feasible for only a few years, there has been significant progress and modification in the use of priming solutions for these bypass units. With the early use of heart-lung machines in the mid-1950's, all surgeons used a 100% blood prime for cardiopulmonary bypass. This, of course, would be the logical priming fluid for the pump oxygenator, but in parallel with the extensive work on shock, there has been greater use of plasma expanders and non-blood solutions for pump priming.

The Current Status of Priming Solutions for Pump Oxygenators

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At the present time, virtually all of the open-heart teams in this country are using some form of hemodilution in the priming of their heart-lung machines. It has been estimated that the majority of open-heart teams in this country are currently using a 50% blood prime with the remainder of the priming volume made up from Ringer's solution or D5W. At least two active surgical groups are using a 100% non-blood priming solution, either D5W or Ringer's solution.

In addition to the use of the basic 50-50 priming solution in most cardiac centers, a number of surgeons will add small amounts of the osmotic diuretic, Mannitol, to the priming solution to improve renal function during bypass. Other surgeons may substitute low molecular weight dextran for part of their non-blood priming volume. The low molecular weight dextran is felt to minimize the problem of blood sludging and thus improve tissue perfusion. There have been, however, a few adverse effects related to the use of low molecular weight dextran in priming solutions. These adverse reactions include an anaphylactic type of reaction in a very few patients, renal shut-down in a few patients and enhanced post-operative bleeding in a few additional patients.

At the present time, at The Johns Hopkins Hospital, we will ordinarily prime our bubble oxygenator with 50% heparinized blood and 50% Ringer's solution. In the typical adult case for open-heart surgery, we will ordinarily request four units of fresh, heparinized blood for priming the heart-lung machine and then will use an equal amount of Ringer's lactate. We have preferred to have heparinized blood drawn the morning of surgery.

We also obtain two to three units of fresh citrated blood which we have available at the end of the open-heart procedure to replace post

pump blood losses. In addition, four to six units of banked citrated blood which can be used in the post-operative period in the recovery room are available. It is somewhat of an inconvenience for the donors and for the personnel in the blood bank to provide this fresh blood on the morning of surgery but it has greatly reduced the problems of post-operative bleeding. It is really quite unusual to observe severe post-operative bleeding in our patients and this appears to be related to the use of fresh blood for the priming of the heart-lung machine and the availability of fresh, citrated blood post-operatively.

There are several advantages to the 50-50 blood-Ringer's prime over the 100% pure blood prime. The main advantage is that the requirements for the fresh, heparinized blood are reduced by 50% and there is fairly good evidence that with this hemodilution technique there is better capillary flow and better tissue perfusion, particularly when a moderate degree of hypothermia is used. We have been somewhat reluctant to use the 100% non-blood prime for the more critically ill heart patients because of the possibility of overloading the patient with fluid which could lead to post-operative pulmonary edema. It appears that we will be using the 100% non-blood prime more and more for simple open-heart procedures but that we will continue to use the 50-50 prime for the more complicated valve replacement cases.

One specific problem related to the priming of the heart-lung machine is that we frequently schedule a patient for a closed mitral valve commissurotomy and on occasion, we find a situation where we would like to proceed with a direct-vision commissurotomy or a valve replacement. Rather than requesting that the blood bank obtain four units of heparinized blood which would limit its use for other patients, we ordinarily request four units of fresh, citrated blood. If open-heart surgery is required, then the citrated blood is used to prime the heart-lung machine along with the Ringer's solution and we add 20 mg of heparin for every unit of citrated blood. In this way, if the patient does not require open-heart surgery, the citrated blood can be used for other patients.

Another special problem is the patient with tetralogy of Fallot and a very high hematocrit. We frequently will operate on such a patient with a hematocrit ranging from 65 to 80, and in this case, we purposely use a greater proportion of Ringer's solution in the oxygenator prime.



As with any major procedure in medicine, the trend with cardiopulmonary bypass has been to greater and greater simplification of the overall system. Part of this trend in simplification is reflected in the increased use of non-blood solutions for priming the heart-lung machine. Of course, even if most of the open-heart cases could be performed with a non-blood prime, there would still be the requirements of several units of citrated blood for the replacement of intraoperative and post-operative blood losses. The continuing improvement in techniques of profusion and the techniques of surgery have worked out to the advantage of the patient. The operative mortality for most major cardiac procedures has been reduced to below 10% in most of the major cardiac centers at the present time.

HEMORRHAGIC DISEASE

Transfusions are administered to patients with hemorrhagic disorders in order to: a) correct anemia and hypovolemia following acute hemorrhage, b) correct anemia associated with chronic bleeding and c) correct the coagulation abnormality and affect hemostasis.

Consideration of measures designed to correct the underlying coagulation abnormality requires precise diagnosis of the defect(s) especially since the introduction of concentrates of coagulation factors. Some patients, for example, with acquired deficiencies of fibrinogen, have multiple coagulation defects, and transfusions of whole blood may be indicated in attempts to correct the defects.

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Acquired deficiencies of fibrinogen may occur in association with a variety of conditions including certain complications of pregnancy (i.e. premature separation of the placenta, prolonged retention of a dead fetus, amniotic fluid embolism, etc.); various malignancies (especially carcinoma of the prostate); massive intravascular hemolysis, (i.e. hemolytic transfusion reactions); gram-negative septicemia; certain specific infections; purpura fulminans; extracorporeal circulation procedures; and snake bites. Deficiency of fibrinogen may occur as the result of 1) increased utilization of fibrinogen (i.e. intravascular coagulation resulting in the defibrination syndrome), 2) increased destruction of fibrinogen (i.e. fibrinogenolysis resulting in the fibrinolytic syndrome), and/or 3) decreased synthesis of fibrinogen.

Most acquired deficiencies of fibrinogen are the result of diffuse intravascular coagulation and defibrination, although evidence of fibrinolysis may occur as a secondary phenomenon. Spontaneous fibrinogenolysis and decreased synthesis rarely are primary factors.

Patients with the defibrination syndrome usually are found to have multiple defects of coagulation, presumedly due to consumption of various coagulation factors. In addition to hypofibrinogenemia, thrombyocytopenia is almost invariably noted, and the levels of prothrombin (Factor II), proaccelerin (Factor V) and antihemophilic factor (Factor VIII), often are reduced.

The causes of the defibrination syndrome generally are self-limiting, but serious bleeding may occur. The sudden onset of unexplained bleeding during a surgical procedure may be the first clue that a patient has received incompatible blood —other symptoms of the transfusion reaction can be obscured by general anesthesia. Development of the defibrination syndrome following a hemolytic transfusion reaction presumedly is the result of the rapid destruction of the transfused red blood cells with release of pro-clotting substance into the circulation and subsequent intravascular coagulation. The risk of hemorrhage usually is limited to the first 24 to 48 hours since fibrinogen and the other plasma coagulation factors return to normal within approximately 24 hours and the platelets return to normal within three to five days following a hemolytic transfusion reaction. The acute defibrination syndrome is encountered most often as a complication of pregnancy, but again the process is self-limiting. Fibrinogen and the other plasma coagulation factors usually return to normal within 24 hours and the platelets return to normal within three to five days following delivery.

The principles that Dr. Rutherford outlined for the treatment of hemorrhagic shock and anemia are applicable in the management of patients with the defibrination syndromes. Replacement of red blood cells and correction of hypovolemia obviously are necessary when there is massive hemorrhage and shock, and therapy designed to correct the coagulation abnormalities should be initiated. Prompt administration of adequate amounts of fresh whole blood is desirable because of the multiple coagulation defects.

The use of component therapy also should be considered. Fibrinogen can be administered as an adjunct to transfusion of whole blood when there is massive hemorrhage, and component therapy alone can be considered if there is little or no bleeding. However, transfusions of blood or components of blood are not always required in the absence of bleeding since the defibrination syndrome usually is self-limiting. The clinical status of the patient, the cause and potential reversibility of the defibrination syndrome, and the nature of the coagulation defects influence the need and the choice of therapy. Administration of fresh whole blood is indicated in patients with multiple coagulation defects associated with the defibrination syndrome when there is massive hemorrhage and shock.

The mortality rate associated with gastrointestinal hemorrhage depends on the age of the patient. The elderly are more seriously affeeted. It also depends on the eause of bleeding. A person with cirrhosis and bleeding is at greater risk than the 20-year-old with a bleeding duodenal uleer. The amount of blood lost is also a major faetor. Not every person with gastrointestinal hemorrhage needs to be transfused. Some persons are adequately managed by iron therapy if they have stopped bleeding.

GASTROINTESTINAL HEMORRHAGE

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Features Unique to Gastrointestinal Bleeding

There are several features of bleeding into the gastrointestinal tract that should be stressed.

■ In contrast to external bleeding and shock, where the amount of blood loss is known, blood loss into the gastrointestinal tract may not be obvious because the person may retain a large amount of blood in the stomach, small intestine or colon. Therefore, the amount vomited or passed in the bowel movements cannot be used to accurately estimate the amount of blood replacement necessary.

■ Bleeding from peptic ulcer disease tends to be episodic. Since this condition is responsible for 60% of the bleeding in most community hospital series, it is important to recognize its episodic nature. A patient bleeds for 30 minutes then he stops. He may not bleed again but at least 25% of the patients will rebleed. These episodes may not be obvious since the patient may not be vomiting or he may not be passing any black stools. Therefore, a principle of the management of gastrointestinal hemorrhage, if the blood loss has been massive, is to repair the blood volume deficit so that the patient can withstand the sudden loss of another 1,000 or 1,500 cc of blood. The patients who die usually have not been adequately prepared for the second, third or fourth episode of bleeding.

■ The estimation of the amount of blood loss is difficult in gastrointestinal bleeding but is extremely important in the satisfactory management. The potentially confusing features include the fact that a person can lose approximately one-fourth of his blood volume and not elevate the pulse rate or lower the blood pressure. This is especially true in older persons. Therefore, we cannot always follow the vital signs in a supine patient when trying to determine the adequacy of replacement. In addition, the initial hematocrit and hemoglobin values obtained in the gastrointestinal "bleeder" are often falsely high and are not a true measure of the circulating blood volume. These values will tend to fall in the first 6 to 24 hours as equilibration occurs. This does not necessarily indicate further bleeding. The equilibration is due to shifts of extracellular fluid into the vascular space as well as reabsorption of fluid and electrolytes from the blood that remains in the gastrointestinal tract. It has been shown that if a liter of blood is placed into the gastrointestinal tract of a healthy person, 750 cc of the fluid is absorbed as well as sodium and potassium. Therefore, an initial hematocrit of 29 or 30 can be very misleading since the physician may develop a false sense of security, feeling that the patient has not bled very much—but then in the next 6 to 24 hours as his hematocrit falls to

25, it is then realized that bleeding has been more significant than originally thought. In a series of patients who died from gastrointestinal bleeding it was found that the initial blood loss had been underestimated by 50% because the house officers had relied upon the hematocrit and hemoglobin and had not transfused patients whose initial hematocrits were over 30. Most of the patients who died rebled at least four times and were not prepared for this subsequent bleeding.

Estimation of the Volume of Blood Loss

There are several clinical features which help the physician to estimate the amount of blood that has been lost (Table 1).

TABLE I

Estimates of Blood Loss

Guaiac positive stool	At least: 6 cc
Melena (black stool)	At least: 50-80 cc
More than 1 black stool/24 hrs.	¼ of blood volume
Shock when upright	¼ of blood volume
Massive hematemesis	½ of blood volume
Shock when recumbent	½ of blood volume
Pallor of palmar creases	½ of blood volume
Admission Hct less than 30%	½ of blood volume
Admission Hgb less than 10 gm	½ of blood volume

Fifty cc of blood are necessary to turn the stool black. Therefore, a person with melena has lost at least that much blood and usually a lot more. If a patient has had more than one tarry-black bowel movement in 24 hours, he has probably been depleted of at least one-fourth of his blood volume. The patient who has vomited large quantities of blood, filling several pans, has probably lost at least one-third of his blood volume. If a patient is in shock while lying on the examining table, he has lost at least one-half of the circulating blood volume. The color of the conjunctiva and skin are not very helpful in assessing acute blood loss, but pallor of the palmar creases of the hands is a significant finding. If the initial hematocrit on admission to the hospital, before equilibration has taken place, is below 30, the blood loss is also massive—probably at least 2,000 cc.

It is true that 75% of patients bleeding from peptic ulcers bleed only once and then stop but, unfortunately, we have no way to predict whether or not a patient is going to rebleed. Some patients whose bleeding has not been massive and in whom the source of bleeding is fairly obvious, do quite well with conservative medical management and iron therapy without blood transfusion. On the other hand, the patient who has already lost 1,000 to 2,000 cc of blood is severely incapacitated if he undergoes another massive bleeding episode. Therefore, he is probably going to need three or four units of blood, that is 1,500 or 2,000 cc of blood, or the equivalent of packed red cells.

In the management of the gastrointestinal bleeder it is usually the practice to use whole blood. It should be stressed that the reason for transfusing the patient rapidly is that you want to prepare him for another episode of bleeding if this occurs. This is especially true in elderly persons.

Speed of Replacement

It has often been found that blood transfusions have been given too slowly by medical departments. In one survey, internists seldom gave 1,000 cc an hour except when the patient was being prepared for surgery or when he was actually in the operating room. In this situation the use of two units of blood, one in each arm, is helpful. Another factor in under-transfusion has resulted from delay in instituting blood therapy. This delay was the longest on the patient's arrival at the hospital. In the series of fatalities mentioned earlier, there was often a two to four hour lapse before the blood was actually given.

Adequacy of Replacement

A patient may have lost 25% of his blood volume and the pulse rate and blood pressure may remain normal while he is lying in bed. If the pulse rate rises rapidly or blood pressure falls as he sits up, this can be used as an indication that he has not been adequately transfused. The patient's urinary output is another helpful parameter. When a patient is adequately hydrated, he should put out at least 500 cc of urine per day. Measurement of the central venous pressure is a helpful procedure in determining the adequacy of blood replacement. This may help to avoid over-transfusion and is useful in elderly patients, those with cardiovascular disease or those patients with massive bleeding. Measurement of the circulating blood volume is not accurate in an acute situation before stabilization.

Diagnostic Procedures

We have discussed the first part of management of the GI bleeder—estimating blood loss and instituting replacement. The second phase, which should start at almost the same time, is the determination of the site of bleeding so that

proper therapy can be applied. The early and accurate establishment of the source of bleeding allows the physician to provide the best medical and surgical care.

Some of the causes of GI bleeding encountered in private and community hospitals are shown in Table 2. These are contrasted with the sources of bleeding in a city hospital series. In private hospitals, 60% of the bleeders had peptic ulcer but in a city hospital population the documented incidence of gastritis rose. Acute hemorrhagic gastritis is often associated with alcohol or aspirin ingestion. This is an important condition to recognize since it is usually self-limited and, if possible, is best treated medically. With the increasing use of emergency endoscopy in GI bleeding, it is probable that gastritis will be found to be even more common in private hospitals as well.

TABLE 2
Causes of Upper Gastrointestinal Hemorrhage

	"Private Hospital"	"City Hospital"
Peptic Ulcer		
Duodenal	50%	30%
Gastric	10%	4%
Gastritis or acute ulcer	10%*	25%*
Esophageal varices	8%	20%
Cancer—stomach	3%	2%
Hiatal hernia	2%	2%
Other	2%	2%
Unknown	15%	15%

* Incidence higher when emergency gastroscopy used routinely.

A series of diagnostic maneuvers are undertaken as the patient is being stabilized with blood transfusions. Initially, we want to know if the site of bleeding is in the "upper" GI tract, that is proximal to the ligament of Trietz including the esophagus, stomach and duodenum, or the "lower" GI tract, that is that area distal to the ligament of Trietz.

Hematemesis indicates an upper GI tract lesion. If vomiting of blood has not occurred, a nasogastric tube is passed into the stomach to look for blood or coffee-ground material. If it is present, then the site is in the upper GI tract. If there is no blood in the stomach, the site is usually distal to the ligament of Trietz. With upper gastrointestinal bleeding, ice water lavage is helpful in removing clots and perhaps diminishing the bleeding from erosive gastritis. When the patient's condition is stabilized by transfusion, esophagoscopy and gastroscopy are performed looking for esophageal varices, erosive gastritis or blood regurgitating through the pylorus from the duodenum. An upper GI series is also performed soon after admission. This may precede or replace endoscopy if a lesion is seen or if the person has a clear history of duodenal ulcer. It is important to stress, however, that the presence of a lesion on X-ray does not prove that that lesion is the source of bleeding. Therefore, endoscopy is sometimes necessary to diagnose conditions such as erosive gastritis. If the bleeding is from the lower GI tract, proctoscopy and a barium enema are the initial procedures performed. The passage of a thin tube into the small bowel to aspirate the contents at various levels may help to localize the source of bleeding. Selective celiac artery angiograms have been helpful in some patients. By utilizing endoscopy and X-ray in the first or second day of admission, the site of bleeding can be found in about 85% of the patients. When the diagnosis is established, the proper therapy can be employed.

Types of Blood Transfusions

If it is decided that a person with gastrointestinal bleeding needs transfusions, whole blood usually is given. In some centers, packed red cells are available in excess. This component can be used in place of whole blood. This may be helpful in elderly patients or those with cardiovascular disease in whom we are trying to avoid congestive heart failure. In the discussion of blood transfusions it should be mentioned that many patients with GI bleeding do not have to be transfused and if their condition has stabilized, the use of iron therapy will be sufficient.

Freshly collected blood is utilized in some patients with cirrhosis of the liver if they have a generalized bleeding disorder. Fresh blood (less than one day old) will provide platelets if the patient has marked thrombocytopenia secondary to hypersplenism. If it is felt that the generalized bleeding disorder is secondary to the deficiencies of several plasma volume factors, then at least four or five units of relatively fresh plasma or blood (less than four to five days old) will be needed to completely correct the first stage clotting defects. It is stressed that not every person with cirrhosis and GI bleeding needs fresh blood —this should be reserved for those with a generalized clotting disorder.

DIAGNOSIS AND TREATMENT OF THE HEMOPHILIAS

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Local measures, when possible, are very important means of controlling hemorrhage in hemophiliacs (as for lacerations and bitten tongues.) Uncomplicated dental extractions may be accomplished without transfusional therapy of any kind, providing the dentist is aware of the problem and uses appropriate local measures. When a patient is not seen until many hours after the onset of a hemarthrosis, we usually do not administer plasma, because such bleeding usually stops spontaneously. However, plasma may be indicated if such an episode is seen at the onset. Major soft tissue bleeding, including intra-abdominal, retroperitoneal, and central nervous system bleeding, should be treated aggressively. Intra-abdominal bleeding may mimic any of the usual causes of an acute surgical abdomen, but surgery often is contra-indicated. Although the indications for surgery will change as concentrates become available, such surgery will remain hazardous and one should remain conservative in dealing with these patients. While circulatory overload is not a problem with concentrates, one is still faced with allergic reactions, hepatitis, variable anti-hemophilic globulin concentrations, hemolysis in the recipent, and of course, cost. Careful laboratory monitoring of such patients will remain mandatory to assure that the appropriate coagulation factor, in amounts adequate to produce normal hemeostasis, is being administered; and to assure that a circulating anti-coagulant has not developed. Anti-hemophilic globulin levels should be elevated to 15-25% for soft tissue bleeding, and to normal levels if possible for central nervous bleeding, or prior to surgery.

In the future, hopefully unlimited supplies of concentrates of coagulation factors will make their use possible in all situations, but at present the supply is limited and the cost is high. Fresh frozen plasma continues to be useful, and provides adequate levels of AHG for many hemorrhagic episodes. The use of concentrates makes imperative the establishment of the correct diagnosis before treatment is undertaken.

Table I lists the hereditary hemorrhagic disorders that constitute the group of diseases called the hemophilias. Hemophilia A, the classical form of hemophilia, is an X-linked recessive disease, characterized by a deficiency of Factor VIII or anti-hemophilic globulin (AHG). Von Willebrand's disease also is associated with a deficiency of Factor VIII, but differs significantly from Hemophilia A (Table II). It is a non-sex linked disorder; males and females are equally affected, the bleeding time often is prolonged, the tourniquet test may be positive, and abnormal capillaries have been reported. Patients with von Willebrand's disease are said to show a decreased platelet adhesiveness; but the clinical significance of this test remains unclear, and the diagnosis of von Willebrand's disease cannot be based solely on an abnormally low platelet adhesiveness.

TABLE I

The Hemophilias

Hemophilia A (Factor VIII)*
von Willebrand's disease (Factor VIII)*
Hemophilia B (Factor IX)*
PTA Deficiency (Factor XI)*

* Deficient coagulation factor.

TABLE II

von Willebrand's Disease

1. **Factor VIII (AHG) deficiency**
2. **Autosomal dominant**
3. **Long bleeding time**
4. **? Abnormal capillaries**
5. **Low platelet adhesiveness**
6. **Unique delayed response to plasma with production of new AHG *in vivo***

Most importantly, patients with von Willebrand's disease demonstrate a unique delayed response to plasma. In contrast to Hemophilia A, the maximum level of AHG following transfusion of plasma or certain plasma fractions to patients with von Willebrand's disease usually occurs 4-16 hours after transfusion; and the levels of AHG following transfusion exceed those that can be accounted for by the AHG contained in the transfused material. Furthermore, the AHG concentration may not return to pretreatment levels for 24 hours. Responses of this type have been interpreted as demonstrating that a factor in normal blood is capable of stimulating the production of new AHG, *in vivo*, when transfused into patients with von Willebrand's disease. The same response can be produced by transfusion of either hemophilic plasma or normal serum, neither of which contains significant amounts of AHG. Von Willebrand's disease also differs clinically from Hemophilia A. Hemarthroses are relatively rare and mucous membrane bleeding (gastrointestinal, gingival, uterine) is very common in von Willebrand's disease, in contrast to the pattern of bleeding in Hemophilia A.

Hemophilia B (Christmas disease) is due to a deficiency of Factor IX (PTC). Hemophilia B, like Hemophilia A, is an X-linked recessive disorder; males are affected, but females are asymptomatic carriers. These two disorders cannot be distinguished on the basis of the clinical picture, although Hemophilia B may be milder. PTA deficiency is a relatively mild coagulation disorder due to the absence of Factor XI, and abnormal bleeding often occurs only after major trauma or surgery. PTA deficiency and von Willebrand's disease are the only two disorders in this group in which males and females are affected.

The family history, and pattern and severity of bleeding provide important clues to the diagnosis, but specific laboratory tests are required for exact diagnosis. Specific diagnosis is particularly important since it determines the type and amount of therapy required in a particular situation.

Laboratory Diagnosis of the Hemophilias

Table III lists some of the tests used to detect deficiencies of Factors VIII, IX, or XI. The clotting time (Lee-White) is the least sensitive test for the diagnosis of these disorders. In some large series, as many as 30% of patients with hemophilia had normal clotting times (i.e. had AHG levels greater than 5% of normal). The prothrombin consumption test is somewhat more sensitive and does not become normal until the AHG, PTC, or PTA level is about 10% of normal; hence it will detect a larger percentage of hemophiliacs. The partial thromboplastin time (PTT) is not normalized until the deficient factor is approximately 20% of normal, and therefore detects an even larger proportion of patients than either of the first two tests listed. The last, and most sensitive, is a specific assay for whatever factor one suspects is deficient. Thus, a normal clotting time may lead to the incorrect conclusion that a patient is normal, and does not rule out a significant deficiency.

TABLE III

Laboratory Diagnosis of the Hemophilias

1. **Clotting time**
2. **Prothrombin consumption test**
3. **Partial thromboplastin time**
4. **Specific Assay**

Treatment

The half-life of transfused Factor VIII is approximately 12 to 16 hours. The amounts of fresh frozen plasma needed to raise the anti-hemophilic globulin level high enough to permit major surgery (at least 50% of normal) often produce circulatory overload. Furthermore, repeated transfusions often are required in patients with Hemophilia A following surgery or trauma (for seven to ten days), since delayed bleeding is very common. Reliance on fresh frozen plasma has made it essentially impossible to maintain normal levels, and therefore the ability to perform surgery in hemophiliacs has been limited.

Concentrates of anti-hemophilic globulin are currently being produced by many methods and their increasing availability will make surgical procedures more feasible in patients with Hemophilia A. AHG-rich fibrinogen has been available for many years, and is produced by a variation of Cohn fractionation. AHG concentrates prepared by cryoprecipitation are in use in many hospitals because this is a relatively inexpensive way to produce concentrated AHG, and can be carried out in any hospital blood bank. Concentrates of even higher potency have been produced more recently by precipitation of AHG with glycine, ethanol, or polyethyleneglycol. These concentrates have in common a relatively low salt and protein concentration, so that large quantities can be given without risk of circulatory overload. However, even with concentrates, the half-life of transfused AHG remains only 12-16 hours, and the bleeding patient utilizes this coagulation factor at a more rapid rate (T½ of four to six hours). Although the current literature is optimistic, major surgical procedures should be undertaken only when absolutely necessary, and only with appropriate laboratory control to assure that adequate levels of AHG actually have been achieved. Formulas to predict the total amount of transfusional therapy required are only approximate, and cannot be relied upon to assure adequate hemostasis.

Although equally high levels have to be reached to effect hemostasis in patients with von Willebrand's disease, this is more easily accomplished because of the ability of such patients to synthesize new AHG *in vivo*. However, this response can not be assumed, and each patient with this disorder must be tested to assure his ability to respond, since all patients do not respond similarly, and a given patient's response may vary with time.

Factor IX deficiency (Hemophilia B, PTC deficiency) is said to be more easily treated, and the half-life of Factor IX (PTC) is reportedly longer than Factor VIII. In our experience, however, it has been just as difficult to elevate Factor IX levels as Factor VIII levels, and treatment should not be undertaken lightly. A concentrate of Factor IX will probably be available in the near future. Factor XI deficiency is apparently more easily treated with smaller volumes of plasma than are needed for Factor VIII or IX deficiency.

INDICATIONS FOR PLATELET TRANSFUSIONS

The use of platelet transfusions to improve hemeostasis in patients with bleeding due to thrombocytopenia is well established. Maximal homeostatic effectiveness is achieved only after transfusion of viable platelets that circulate in the recipient in adequate numbers. The usefulness of, and the indications for, platelet transfusions are influenced by the etiology of the platelet deficieney.

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Idiopathic thrombocytopenic purpura (ITP) is the term used to describe a syndrome characterized by thrombocytopenia of unknown cause. Immunologic factors appear to be involved in the etiology of ITP in many instances. Plasma from patients with ITP often will transiently suppress circulating platelet levels when infused into normal recipients, infants of mothers with ITP may be thrombocytopenic at birth and for the first weeks of life, and the survival of transfused platelets in patients with ITP often is very short and may become progressively shorter following repeated transfusions.

The abbreviated life span of transfused platelets limits the usefulness of platelet transfusions in patients with ITP. In general, platelet transfusions are used in ITP only as emergency therapy during periods of crisis, such as intracranial hemorrhage, or massive gastrointestinal or uterine hemorrhage. Platelet transfusions usually are not required prior to splenectomy unless serious bleeding is present preoperatively, but they should be considered prior to other types of unavoidable surgery.

Platelet transfusions have their greatest usefulness in the management of patients with thrombocytopenia due to decreased production of platelets (e.g.—aplastic anemia or leukemia). Survival of

transfused platelets usually is normal in such patients, but at best the beneficial effects of platelet transfusions persist only for a few days, and isoimmunization against platelets has been noted following repeated transfusions. In general, the indication for platelet transfusions in such patients is the occurrence of significant spontaneous bleeding rather than the patient's platelet count. Prophylactic platelet transfusions usually are not administered to patients with long-standing, chronic thrombocytopenia (e.g. aplastic anemia), but they may be life-saving during period of crisis and severe hemorrhage. Platelet transfusions are useful in the prevention and control of bleeding during periods of severe, reversible thrombocytopenia such as occurs during therapy with oncolytic agents.

Thrombocytopenia apparently due to dilution of the recipient's blood with blood that contains nonviable platelets occurs following rapid administration of large amounts (5,000 to 7,000 ml in 24 to 48 hours) of *stored* blood. The degree of suppression of platelet levels in the recipient is directly related to the amount of blood infused and the rate of infusion and inversely related to the time of storage of the blood. The platelets will return to normal within three to six days after the transfusions, and often no therapy is required. Platelet transfusions and/or administration of fresh whole blood are indicated if there is significant bleeding due to the thrombocytopenia. Administration of *fresh* blood prevents thrombocytopenia following massive blood replacement, but splenectomy has no effect.

The principles involved in the use of platelet transfusions have been summarized in several recent publications including the report of a National Academy of Sciences-National Research Council Task Force (*Transfusion* 6:1-63, 1966). At the present time the only generally available sources of viable platelets for transfusion are fresh whole blood and platelet-rich plasma or platelet concentrates prepared from fresh blood. For optimal effects, the platelets should be administered within six hours of the time of collection of the blood. Platelets from blood 6 to 24 hours old may be used in emergency situations, but their life span will be less than that of "fresh" platelets. The logistic problems in the use of platelet transfusions are apparent because of the limitations of supplies of fresh blood. Various methods for preserving viable platelets are being investigated.



The Use of Platelet Transfusion in the Treatment of Leukemia

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The development of chemotherapeutic agents for the control of acute leukemia and other neoplastic diseases has further stimulated the investigation of the important complications of this group of diseases, such as hemorrhage and infection which have been responsible for death in a majority of instances. The hemorrhage associated with thrombocytopenia occurs predominantly in the gastrointestinal tract, the lungs, within the cranial vault, the skin, the genitourinary tract, the heart, and the lymph nodes in that order of frequency.

The use of chemical agents which may produce a severe depression of the bone marrow and consequently thrombocytopenia has further emphasized the need for the development of means to control thrombocytopenic hemorrhage.

It has been shown in patients with acute leukemia there is a direct relation between the frequency of hemorrhage and platelet count. The frequency and severity of hemorrhage increases at lower platelet counts with no threshold level observed.[1] Platelet replacement therapy in such patients can be repeatedly effective in increasing the circulating platelets and arresting hemorrhage.[2] Control of thrombocytopenic bleeding usually requires considerably larger quantities of platelets than can be administered as fresh whole blood.

The development of closed plastic systems for the concentration and separation of platelets and other blood components permitted these procedures to be included into "routine" blood banking. The subsequent utilization of plasmapheresis has further extended the availability of platelets for clinical study and for the control of thrombocytopenic hemorrhage. Plasmapheresis may be performed on a single donor at rates of at least one liter of plasma per week.[3, 4]

Several methods for platelet separation and concentration are now in use. A number of factors such as different volumes of units of blood collected, the rate of collection, temperature and speed of centrifugation, nature of anticoagulant and the period between blood collection and termination of the platelet transfusion vary from institution to institution. Ideally, the platelets should be infused within six hours for maximal effectiveness.[5]

At the Baltimore Cancer Research Center during the past two years we have performed 2,300 platelet transfusions, representing 15,000 units of fresh whole blood, on 186 severely thrombocytopenic patients, mostly with acute leukemia. While a number of recent papers reflect the increased experience with platelet transfusions in thrombocytopenic patients, usually children with leukemia,[6-9] our experience is largely with adults.

The evaluation of hemeostatic agents in thrombocytopenia is complicated by the inherent variability of the course of bleeding due to lack of platelets. One reliable method of assessing the efficacy of platelet transfusion in man is by demonstrating the presence of the transfused platelets in the circulation. Controlled studies by Djerassi

have indicated that a post-transfusion platelet increment of $< 20{,}000$ will arrest bleeding in 33% of occasions while post-transfusion increments of $> 40{,}000$ will arrest bleeding in 81% of occasions.[7]

We, along with others, have observed hemeostasis in the absence of any significant platelet rise which may be attributed to increased platelet utilization. The cessation of hematuria and epistaxis is more evident, and effects on cutaneous and gastrointestinal bleeding is more difficult to quantitate.

We have tried to assess techniques for the most efficient methods for platelet separation and administration. Immediate survival is measured by the maximum increment in the recipients' platelet count. It is commonly expressed as increment in count per 10^{11} platelets administered per square meter of body surface area. The average increment is roughly proportional to the number of platelets given (Fig. 1). The level of pretransfusion count does not seem to affect the increment. After transfusion of fresh platelet-rich plasma a linear survival curve is noted (Fig. 2). However, platelet-rich plasma stored at 4 C for 24 hours retain 60% of their effectiveness in elevating the platelet count, and we can expect benefit in an emergency from one-day old platelet-rich plasma. After infusion of platelet concentrates the average recovery is only half as great as platelet-rich plasma (Fig. 3).

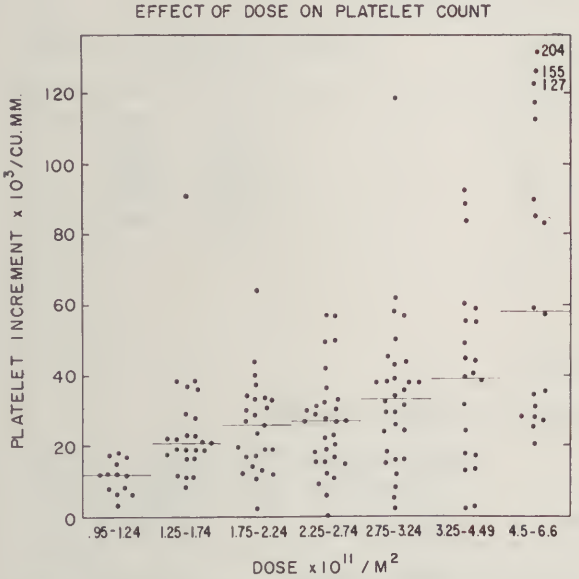


Figure 1: Effect of dose of platelets transfused on increment of platelet count. Median values shown. (Reprinted from Freireich et al [2] with permission of publisher.)

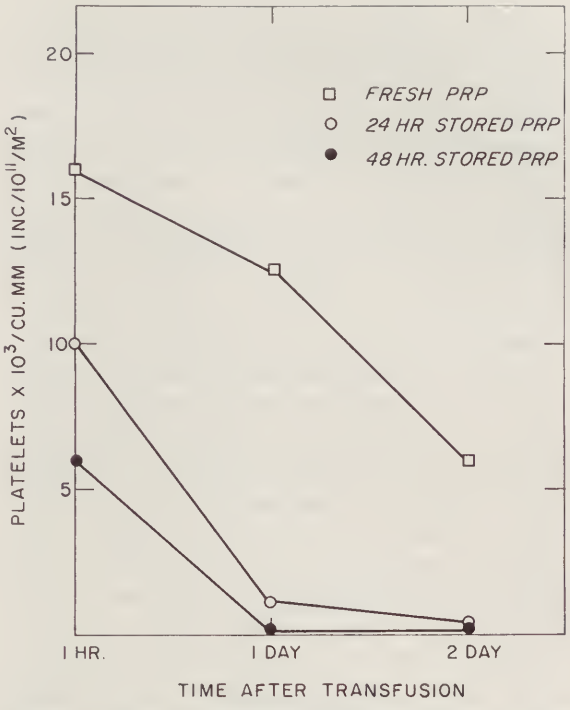


Figure 2: Platelet increment/10^{11}/square meter one hour, one and two days after transfusion of platelet-rich plasma (PRP). (Reprinted from Levin et al [5] with permission of publisher.)

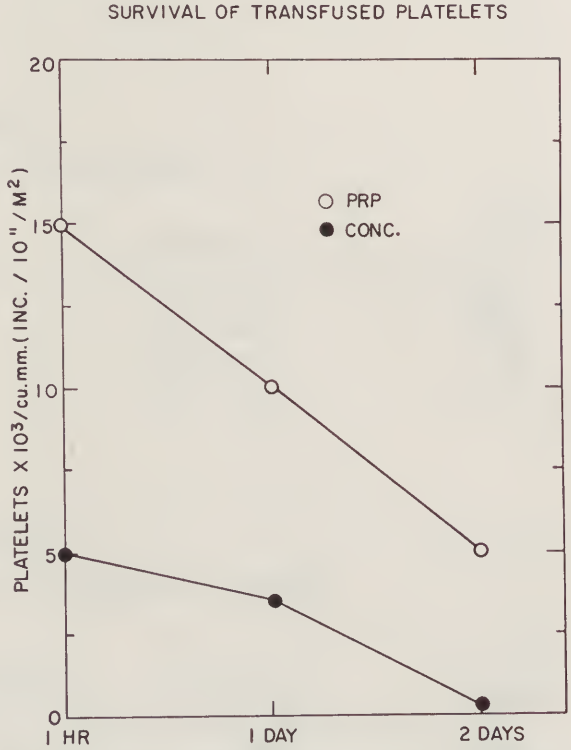


Figure 3: Median increment and survival of platelet-rich plasma (PRP) and platelet concentrates. (Reprinted from Levin et al [10] with permission of publisher.)

A major reason for the poor recovery after infusion of platelet concentrates is the formation of aggregates or clumps during centrifugation. Increasing the citrate concentration of the anticoagulant, as well as lowering the pH, has been shown to decrease platelet adhesiveness and render platelets less sensitive to thrombin-induced aggregation. When platelet aggregation is reduced by acidifying the platelet-rich plasma prior to centrifugation, the platelet concentrate produced is almost as effective as platelet-rich plasma.[11, 12]

Methods of acidification include the addition of 20-30 cc of additional ACD solution or .25 M citric acid 1 ml/100 ml of platelet-rich plasma. The former is routinely available in the blood bank but has the disadvantage of adding more volume as water while the latter method involves entry into the final container of the highly acidic addition, thus breaking the hermetic seal of standard double-bag plastic blood containers. Recently a method of acidification has been described which takes advantage of the calculated 16% excess of ACD-A anticoagulant in routine blood collection ("Split ACD").[13] Double bag blood containers were modified before use by expressing 15 ml of the contained ACD-A anticoagulant into the satellite bag. The reduced citrate concentration is sufficient to prevent coagulation. After blood collection and centrifugation the supernatant platelet-rich plasma is expressed into the satellite bag containing the 15 ml of ACD-A. The platelet concentrate prepared from centrifugation of the satellite bag has the same disaggregated appearance as concentrates modified by the use of additives. Since platelets are not viable in banked blood, nothing has been lost from fresh whole blood for which platelet concentrates are extracted by the "Split ACD" method. Reconstituted whole blood can thus be stored and handled like ordinary banked blood. As an alternative, cryoprecipitate can be made from the platelet poor plasma as we are presently doing.

Tables I and II illustrate our platelet yields and post-transfusion responses for platelets prepared by these various methods. We did observe a higher increment after infusion of platelet concentrates prepared by the addition of citric acid.

The use of filters in the transfusion of platelets produced no deleterious effects on the platelets (Table III).

TABLE I

Platelet Yields by Platelet Product

Type of Transfusion	Acidification	No. of Transfusions	Platelet Yield/Unit ± 1 SE x 10^{11}
PRP	None	16	1.14 ± 0.08
PRP	Split ACD	16	0.92 ± 0.04
PC	Citric Acid	127	0.87 ± 0.03
PC	Split ACD	475	0.75 ± 0.01

TABLE II

Response to Platelet Transfusion by Platelet Product

Type of Transfusion	Acidification	No. of Transfusions	Post-Transfusion Increment ± 1 SE ($10^3/10^{11}$ plat. adm/M^2) 1 Hr. p-Tx	12 Hr. p-Tx
PRP	None	10	24.8 ± 4.6	11.2 ± 2.1
PRP	Split ACD	15	11.4 ± 2.2	9.6 ± 4.4
PC	Citric Acid	93	22.0 ± 2.1	5.6 ± 0.9
PC	Split ACD	287	14.6 ± 0.8	6.9 ± 0.6

TABLE III

Effect of Platelet Filter* on Increment

	Non-Filter	Filter
No. Units Transfused	481	506
Mean No. Units/ Transfusion	5.53	5.82
No. Paired Transfusions	87	87
Mean One-Hr. Post-Transfusion Increment x $10^3/10^{11}/M^2$	15.3	13.7

* Fenwal HB 182.

One-third of the infused platelets are recovered in the circulation after a platelet transfusion. The observation of considerably higher *in vivo* recovery of similarly prepared platelets in patients with aplastic anemia and other thrombocytopenic states point to the unfavorable conditions in leukemic recipients (fever, infection, splenomegaly). The decrease in platelet count is roughly linear after transfusion and in patients with acute leukemia is generally shorter than it is in other patients. Few of the transfused platelets survive more than two days in adult leukemia recipients. In many patients the platelet count returns to pre-infusion levels in 24 hours. It has been necessary to give platelets from five to ten units of blood every two to three days to maintain a platelet count $> 20{,}000$ most of the time. The frequency of transfusion is dependent upon the magnitude of response and rate of removal. When the supply of platelets for transfusion is limited, treatment may be limited to episodes of clinical hemorrhage. Platelet recovery and survival appear to be lower in the presence of bleeding and with our larger quantities of platelets available we administer platelets prophylactically in an effort to keep the platelet count maintained.

Recipient reactions have been less than 10% and consist predominantly of chills, fever and occasional urticaria. We have not seen severe reactions. Viral hepatitis and isoimmunization are inevitable hazards of transfusional therapy. The latter does not seem to be a major problem in our patients, most of whom are on immune-suppression therapy. Also, it may be that insufficient numbers of red cells are transfused and/or the transfused platelets do not survive long enough to cause isoimmunization.

What is the overall value of platelet transfusion in the management of patients with acute leukemia? The constant threat of bleeding has been reduced. Retrospective studies in several institutions have shown a striking reduction in fatal hemorrhage among leukemic patients since platelet transfusions have been instituted.[8, 14] A higher number of remissions in patients with acute leukemia is possible if severe hemorrhages can be controlled temporarily. The physician has a greater therapeutic index in the administration of myelosuppressive drugs. Thrombocytopenia might not be considered dose-limiting toxicity.

Transfusion therapy is replacement therapy and the primary objective of platelet transfusion is the correction of a platelet deficiency. If this occurs, transfusion therapy is successful.

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Laboratory and Clinical Results with Improved Methods of Preparing Fresh and Frozen Platelet Concentrates

The use of platelet concentrates for the treatment of thrombocytopenia has continued to increase rapidly in the past few years. The best evidence of therapeutic effectiveness has come from studies on leukemia patients in whom mortality from hemorrhage has been reduced by half. Transfusions with adequate numbers of platelet concentrates have also made it possible to carry out planned programs of more intensive chemotherapy.[1, 2]

The clinical effectiveness of platelet concentrates, judged principally by the increase in platelet count, has been improved by minimizing platelet injury caused by ADP-induced clumping. When clumping platelets are resuspended there is evidence of injury as tested by release of ^{14}C-serotonin, release of platelet enzymes, decrease in clot retraction, and there is a parallel reduction *in vivo* of platelet survival despite the great variability in response in thrombocytopenic patients.[3]

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Two methods have been used to prevent injury from ADP-induced clumping. Acidification of platelet-rich plasma with citric acid or ACD solution to pH 6.5 [4, 5, 6] will inhibit ADP clumping, but it has had an adverse effect on Factor VIII activity and has resulted in a marked reduction in yield when acidified plasma was fractionated to produce a high potency Factor VIII concentrate. The adverse effect on plasma fractions was minimized when the pH was brought to 6.8. This was done by adding 2.5 ml of ACD—(A) per 100 ml of platelet-rich plasma, and the frequency of clumping was reduced from 15-20% to 3-4%. The mean increment rise in platelet count per unit of platelet concentrate per square meter of body surface was improved from 5955 without acidification to 7908.[3]

A second method which appears very promising does not require addition of acid or inhibitors.[7, 8] The concentrate is simply incubated prior to resuspension to allow the plasma enzymes to act upon the ADP. Current studies, carried out in conjunction with Drs. Henderson and Yankee, of the National Cancer Institute, show an increment

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rise in platelet count of 12,800, essentially as effective as platelet-rich plasma. The method used is as follows:

1) **Centrifuge whole blood (RC-3, swinging bucket rotor) for 1 min. 40 sec. after reaching a speed of 3,200 RPM.**
2) **Express platelet-rich plasma, and centrifuge (swinging bucket or angle head) for 10 min. at 5,000 RPM.**
3) **Express platelet-poor plasma, leaving 15 ml. with the platelet concentrate and incubate the concentrate for one hour at 23-25 C or for 30 min. at 37 C.**
4) **Resuspend the platelets only after incubation is completed.**

The need for these improvements becomes more evident when one looks at the actual *in vivo* yield from platelet-rich plasma. There is at least 20% mechanical loss in preparing platelet-rich plasma, and the increment rise in platelet count is only 40% of the expected, based on the blood volume and the number of platelets given. It did not seem reasonable to place much emphasis on low temperature preservation when the expected yield would be extremely low. Encouraged by these improvements and by the work of Cohen and Gardner [9] using glycerol and Djerassi et al [10] using dimethylsulfoxide (DMSO) and glucose as protective additives for low temperature preservation of platelets, we attempted to develop a method of low temperature preservation which would be suitable for routine clinical use. A screening program was carried out to evaluate different cooling rates and different additives, e.g. PVP, sucrose, mannitol, fructose, glucose, DMSO, glycerol. Release of ^{14}C-serotonin was used as the principal *in vitro* test.[11] Clinical studies [12] started, using the following procedure: prior to resuspension of the concentrate, the remaining plasma was withdrawn into a syringe containing 1 ml of DMSO and 2 ml of 50% glucose. After mixing with the additive, the plasma was returned to the concentrate, resulting in a concentration of 5-7% DMSO and 5-7% glucose. The platelet concentrate was resuspended, and, using the same syringe, transferred to a freezing container made of 5 mil FEP teflon® tubing (1½ x 8 inches). One to four concentrates of the same ABO group were placed in one freezing container, which was made correspondingly longer. Controlled-rate freezing was discontinued when equally good results were obtained by placing the freezing container in the vapor phase of a —120 C refrigerator. This also made it convenient to freeze large numbers of concentrates; up to 180 units have been processed in one day. The concentrates were stored between —120 and —190 C. Thawing was carried out by immersion in ice water or a room-temperature water bath.

Usually six thawed units were pooled in a triple pack containing an equal volume of plasma in the large bag (ACD removed) and 50 ml of plasma in a side bag. After mixing the platelets and the plasma in the large bag, it was centrifuged, and all plasma and additive possible were expressed into the third pack. The concentrate was then resuspended with the 50 ml of plasma from the second bag.

In vivo tests were carried out in which eight patients received one transfusion of fresh, and one of frozen platelets at different times. The average increase in count was 12,400 after fresh platelets with half remaining at twenty hours, and 6,900 after frozen platelets with one-third circulating at twenty hours. No increase in untoward clinical reactions has been observed with frozen platelet concentrates. If care is taken to minimize transfer losses, it appears that adequate platelet therapy can be achieved by giving two frozen concentrates in lieu of one fresh.

It would be desirable to eliminate all post-thaw washing and to replace the potentially toxic DMSO with glycerol or some equally safe additive. We have made improved freezing containers of teflon® with conventional ports and other containers of a new, experimental bi-oriented polyethylene. Despite the disadvantages of the present method, frozen platelets are clinically useful, relatively inexpensive and, most important, they are available for emergencies nights, weekends and holidays when fresh platelets cannot be obtained. Repeated field tests have shown that it is reasonably convenient to transport frozen platelets over several hundred miles. *In vitro* and *in vivo* studies have shown no difference between platelets frozen for one day or for several months when stored below –120 C.

References will be supplied upon request.

MEDICAL NEWS

John W. Barnaby, MD, has announced a new office location. He is now practicing as a General Practitioner at 1652 East Belvedere Ave. in Baltimore.

* * *

J. Dixon Hills, MD, has joined Ralph G. Hills, MD, and Walter B. Buck, MD, in the practice of Internal Medicine at 3501 St. Paul Street, Baltimore. Dr. Hills will also specialize in cardiology.

* * *

A recent addition to the medical force in Bethesda is **W. G. Edwards, Jr., MD,** who has been a resident in nephrology in the Mayo Graduate School of Medicine, University of Minnesota at Rochester.

* * *

Another resident who has moved to Maryland from the Mayo Graduate School of Medicine is **Mauricio Salazar, MD.**

Dr. Salazar, specializing in colon and rectal surgery, is presently located in Silver Spring.

* * *

Mrs. Rose F. Barry, Executive Secretary of the Board of Medical Examiners has announced her resignation from that post.

* * *

The Baltimore City Health Department sent **Louis V. Blum, MD,** of Baltimore to Rome, Georgia to attend a course in "Clinical Management and Control of Tuberculosis." The course was held the last two weeks in August at the Battey State Hospital. The program is sponsored by the U.S. Public Health Service as part of their continuing education facility.

Dr. Blum was selected to attend the course because of his close association with the Baltimore City Tuberculosis Control Program. He has been working with the program for 26 years.

* * *

James E. Carson, MD, Acting Commissioner of the State's Department of Mental Hygiene, has been nominated as successor to Isadore Tuerk, MD, Commissioner of the department until his retirement July 1st.

Dr. Carson's appointment became official recently when Governor Agnew approved the selection committee's nominee.

* * *

The Chief of the Laboratory of Chemical Pharmacology, National Heart Institute, **Bernard B. Brodie, PhD,** has been awarded an honorary Doctor of Medicine degree from the Karolinska Institutet of Stockholm, Sweden.

The Institutet cited Dr. Brodie for his aid, given through the years, in the training of Swedish medical researchers, and for his various important contributions to medical research.

Dr. Brodie's laboratory at the Heart Institute has gained renown through its contribution to further the understanding of various aspects of biochemical pharmacology. His group has studied mechanisms through which drugs penetrate biological membranes, are distributed into various tissues, become changed to active or inactive metabolites and are eliminated from the body. His laboratory has also studied how drugs alter psysiological and biochemical systems which control the release and metabolism of biologically active amines, the mobilization and transport of fatty acids, and the activity of diverse enzyme systems. In these studies he and his colleagues have aided in developing a variety of drugs and in elucidating some of the reasons for species and individual variation in drug action.

* * *

Abraham M. Rudolph, MD, and **Alfred P. Fishman, MD,** have been appointed to the National Advisory Heart Council of the National Institutes of Health.

Dr. Rudolph is a staff member of the Cardiovascular Research Institute and Professor of Pediatrics at the University of California School of Medicine in San Francisco. His particular interests lie in problems of lung circulation especially those leading to pulmonary hypertension, as well as broad aspects of pediatric cardiology. He is currently engaged in studies of the fetal circulation.

Dr. Fishman, Director of the Cardiovascular Institute of the Michael Reese Hospital and Medical Center and Professor of Medicine at the University of Chicago, is particularly interested in the physiology of respiration and circulation as well as comparative physiology and internal medicine.

Both men will serve four-year terms and will participate in critical evaluation of the programs of NIH's National Heart Institute.

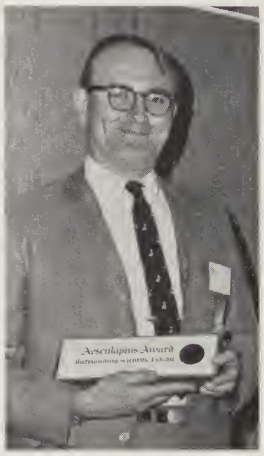
* * *

The Children's Guild, a Community Chest Agency, has introduced a therapeutic educational program for pre-school children with developmental disabilities affecting behavior, language, motor coordination, or learning. Children enrolled in this program are between the ages of three and five. Requirements for admission include the findings of a potentiality for normal or near-normal intelligence.

According to **Mrs. Frederica Bardwell,** Director of Children's Guild, Inc., the program was made possible through a three-year grant from the Hoffberger Foundation.

During the three-year period, the Guild will explore the effectiveness of various educational and therapeutic measures in furthering the social development of children with developmental disabilities. Individual and group counseling of parents will be provided concurrent with the child's enrollment in the preschool program.

* * *



The winner of the Aesculapius Award for his Outstanding Scientific Exhibit on Homocystinuria displayed during the Faculty's Annual Meeting in April, **Charles L. Morreels, Jr., MD,** has been certified a Diplomate of the American Board of Radiology.

* * *

J. Roy Guyther, MD, of Mechanicsville, has been appointed to the Board of Medical Examiners to replace John H. Hornbaker, MD, of Hagerstown, who resigned recently.

Dr. Guyther's interim appointment will extend through the Faculty's 1969 Annual Meeting at which time the House of Delegates will appoint a permanent replacement to complete Dr. Hornbaker's term of office.

A general practitioner, Dr. Guyther also serves as a member of the faculty of the University of Maryland School of Medicine in the Department of Family Practice. He is a graduate of the University. Dr. Guyther's association with the school's Division of Family Practice dates back to when he was a member of the Governor's Commission to Study the Shortage of General Practitioners in Maryland. One of the Commission's recommendations was that a Family Practice division be established at the University of Maryland School of Medicine.

* * *

"The Emergency Treatment of Head Injuries," a 29-minute film, produced by **A. Earl Walker, MD,** Neurosurgeon-in-Charge, The Johns Hopkins Hospital, is now available.

The purpose of the film is to assist the first aid man, rescue squad or policeman in how to treat head injuries at the scene of the accident; as well as provide assistance to the staff of local community hospitals in diagnostic and surgical procedures.

Prints are now available.

* * *

Guy M. McKhann, MD, Associate Professor of Pediatrics and Medicine specializing in neurology and Acting Director of the Department of Neurology at the Stanford University Medical School, has been selected to establish a Department of Neurology at The Johns Hopkins University School of Medicine.

Dr. McKhann, a graduate of the Yale University Medical School, is expected to assume the neurology chairmanship around the first of the year, at which time the new department will formally come into being.

Until now, neurology has been a division of the Department of Medicine, but according to **Vernon B. Mountcastle, MD,** chairman of the selection committee responsible for Dr. McKhann's appointment, neurology has to be made a separate department because of the growing medical importance of "the brain and its behavior."

Dr. Mountcastle said the new department would be clinical in nature and would begin with a professional staff of six, most of whom are now in the school's neurology division. The department hopes to expand to accommodate a staff of 12.

The members of the department will teach at the medical school, supervise residency training in neurology, conduct research, and operate the neurology service at City Hospitals.

To help staff the new department, the United Cerebral Palsy Foundation has established a Dwight D. Eisenhower professorship in neurology, and the Joseph P. Kennedy Foundation has established a similar professorship.

* * *

During the **Maryland Radiological Society's Annual Meeting** held in Hagerstown in June, the following officers were elected for the coming year: **Phillip Myers, MD, president; Henry Startzman, MD, vice-president; Thomas Snyder, MD, secretary; and James Bisanar, MD, treasurer.**

* * *

Edward R. Dana, MD, has been promoted to the rank of Associate Professor of Radiology at The Johns Hopkins University School of Medicine.

* * *

The Maryland Association of Private Practicing Psychiatrists is revising the Maryland Psychiatric Directory. Anyone who has entered private practice since 1966 or who was not included in the previous Directory is requested to contact Mrs. John H. Engel, 939 Radcliffe Road, Baltimore 21204.

* * *

George Sharpe, MD, of Kensington, has been appointed to the Advisory Council on Nursing Home Administration by Wilbur Cohen, Secretary of the Department of Health, Education and Welfare.

The council's purpose is to recommend eligibility criteria for licensing nursing home administrators under the Medicaid program.

* * *

The Johns Hopkins University School of Hygiene and Public Health recently received support from the Rockefeller Foundation to augment research on schistosomiasis, a disease which has been conservatively estimated at having infected some 150-million people.

"Snail fever", as the disease is known by World War II veterans, is caused by a small blood fluke which lives as a parasite. Apparently, man comes into contact with the larvae in water in which host snails are shedding this larvae. The incidence of schistosomiasis is on the upswing in developing countries where new irrigation systems and urbanization are increasing the use of polluted water by large numbers of people.

Research to determine various characteristics of the host snail in order to attempt to curb the spread of the disease and cure its sufferers is being conducted by **Kaz Kawata, DPH,** an assistant professor in the school's department of environmental health.

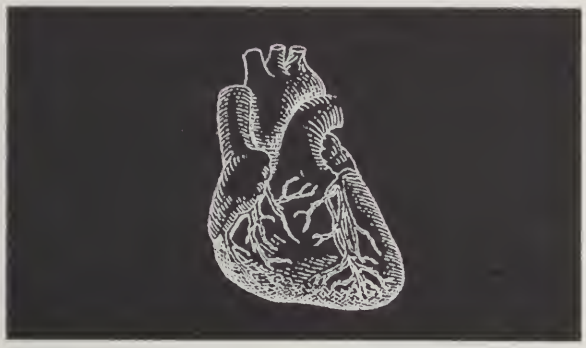
* * *



"After 48 years and approximately 15,000 babies," a recent press release stated, **J. Morris Reese, MD,** of Lutherville, "has decided to limit his medical activities to special consultant work."

Dr. Reese, known as "Pappy," was honored at two testimonial dinners by Bon Secours Hospital. Dr. Reese has been associated with Bon Secours since 1928.

An alumnus of the University of Maryland School of Medicine, Dr. Reese has specialized in the practice and teaching of obstetrics since his graduation in 1920. He is now an Emeritus Professor of Obstetrics and Gynecology at the university. Among other honors achieved during his outstanding career, he has been accorded a Life Membership in the American College of Surgeons and is a Diplomate of the American Board of Obstetrics and Gynecology. Dr. Reese was a founding member of the American College of Obstetrics and Gynecology. Also, he is an immediate Past-President of the Medical and Chirurgical Faculty.



JERRY SALAN, MD, EDITOR

A Service of the Heart Association of Maryland

the heart page

The Nurse's Role in Cardiopulmonary Resuscitation

Extensive clinical experience has established closed-chest cardiopulmonary resuscitation as a proven means of sustaining life in many victims of sudden death. Because the nurse is frequently the first person to discover a patient in cardiac arrest, it is essential that she be able to recognize the problem, initiate emergency resuscitation, and assist with definitive therapy. Since cardiopulmonary resuscitation must begin within four to six minutes of clinical death in order to prevent irreversible cellular changes, the necessity of the nurse's initiating resuscitative measures becomes further apparent. Within a hospital setting, the time required for a specialized resuscitation team to reach a stricken patient usually exceeds the acceptable limits.

DONALD H. DEMBO, MD, Chief of Cardiology, Maryland General Hospital

The Medical and Chirurgical Faculty of the State of Maryland and the Maryland Nurses' Association have approved the propriety of specially trained nurses administering emergency care in cardiopulmonary resuscitation, including intravenous drug administration and defibrillation in those instances where a physician is not immediately available. The National Research Council, American Heart Association, and other health science organizations have agreed to the necessity of the nurse's primary role in cardiopulmonary resuscitation.

The nurse's first responsibility is to recognize cardiac arrest. She can quickly determine the presence or absence of breathing by observing chest movement and by listening and feeling for air exchange at the mouth or nose. Should respirations not be present, she will immediately establish a patent airway by hyperextension of the neck and, using the expired air ventilation technique, ventilate the victim three to five times. She must then immediately check for carotid pulses in the neck and if not palpable, begin closed-chest cardiac compression. Without interruption of expired air ventilation and external cardiac compression, the hospital or industrial emergency resuscitation team plan should be initiated by her call for help.

Having begun resuscitation measures and summoned additional aid, the nurse then must assist with definitive therapy. Specifically, she is responsible for preparing emergency drugs, obtaining resuscitation equipment, supervising the area, and keeping records. As drugs are consumed, replacements must be ordered rapidly and prepared for administration since these medications are given at frequent, regular intervals. Resuscitation equipment includes the emergency cart, ECG machine, and defibrillator. Supervision of the area involves prompt removal of unnecessary equipment and furniture from the room, and patients occupying the same room should be moved out where possible. Often, unnecessary people are present in the area, and it is the nurse's responsibility to assure that only those individuals essential to the resuscitation remain. In addition, despite the busy and tense atmosphere of a cardiopulmonary resuscitation, accurate record keeping is important for self-assessment of a resuscitation program. This includes recording the time lapse between occurrence of arrest and initiation of resuscitation, the fre-

quency and regularity of closed-chest compression, the times of administration and dosages of drugs, and the number and strength of defibrillatory shocks.

Following successful resuscitation, it is the nurse's further responsibility to assist in post-resuscitation care which includes careful monitoring for cardiac arrhythmias and close attention to such physiologic parameters as pulse, blood pressure, urine output and mental status. Special drugs or hypothermia may be used for reducing cerebral edema, and familiarization with these types of therapy is important.

It seems apparent from this discussion that every nurse must thoroughly familiarize herself with the principles and techniques of cardiopulmonary resuscitation. In order for her to be adequately prepared to meet her responsibilities, it is essential that she receive intensive training in the theoretical and practical aspects of closed-chest cardiopulmonary resuscitation. This training should make use of audiovisual aids such as movies and slides, along with carefully supervised sessions that allow each nurse to practice resuscitation on life-like manikins. It is every hospital's responsibility to provide itself with an emergency resuscitation team plan and to train its nurses as part of that plan.

Carefully trained nurses are assuming ever larger roles in resuscitation efforts, particularly in coronary care units. In these areas, nurses may be carefully trained to promptly administer defibrillating shocks to victims of ventricular fibrillation when a physician is not immediately available. Successful resuscitation is enhanced by the rapid restoration of a functional cardiac rhythm.

Assistance with training programs, including instructors and audiovisual aid material, is available through the Heart Association of Maryland.

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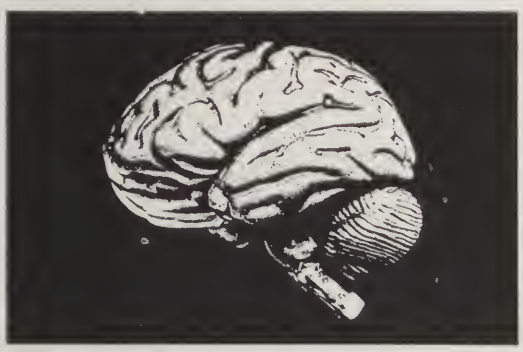
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JAMES E. CARSON, MD, COMMISSIONER
KURT GORWITZ, ScD, STATISTICS DIRECTOR

Maryland State department of mental hygiene

Fact Sheet for 1968 Fiscal Year

In 1968 Maryland's hospitals for the mentally ill again treated a record number of patients, reflecting the continuing rise in admissions. In 1958 these facilities treated 16,197 patients; by 1968 this had increased 45.7% to 23,598. However, due to shortened periods of hospitalization and the continuing decrease in the number of long term patients, the average daily size of the patient population declined 15.7% during this period from 9,147 to 7,711. Detailed data are shown in the following table—

Fiscal Year	Average Size of Patient Population	Total Number Treated During Year	Admissions	Total Separations
1958	9,147	16,197	4,015	4,412
1960	8,576	16,268	4,640	4,751
1962	8,291	17,580	6,221	6,111
1964	8,035	19,424	7,871	8,104
1966	8,102	21,542	9,675	9,735
1968	7,711	23,598	11,997	12,132
Net Change	—1,436	+7,401	+7,982	+7,720
Percent Change	—15.7	+45.7	+198.8	+175.0

A similar upward trend has been observed in virtually all of the 101 clinics and other outpatient centers reported to the Maryland Psychiatric Case Register. Total admissions to these facilities are estimated to have increased 8.1% from 16,161 in 1967 to 17,467 in 1968. Since comparable data have been reported by most states, the question is frequently posed whether or not this reflects a rising incidence of mental illness. This can not be readily answered since the numeric relationship between the number of individuals treated in psychiatric facilities and the total number of mentally disturbed or ill can not be determined. However, it is generally believed that the rate of occurrence of most mental illnesses has not changed appreciably and that these expanding figures therefore primarily reflect the growing acceptance and usage of psychiatric hospitals and clinics for the short term intensive treatment of alcoholism and acute psychoneurotic and personality disturbances.

Substantial overcrowding continued at Rosewood, the larger of Maryland's two hospitals for the mentally retarded. It therefore persisted in its policy of relating the number of admissions to available space and staff. Despite this restrictive policy, the average number of retarded patients at Rosewood and Henryton increased 92 to 3,089 last year. Ten years ago, prior to the opening of Henryton, Rosewood had a patient population of 2,007. In an effort to resolve this chronic problem, the Department is engaged in a three-pronged program involving the construction of additional buildings at Rosewood, the establishment of new facilities in the Baltimore and Washington metropolitan areas and the development, with the Health Department, of coordinated community based services as alternatives to hospitalization

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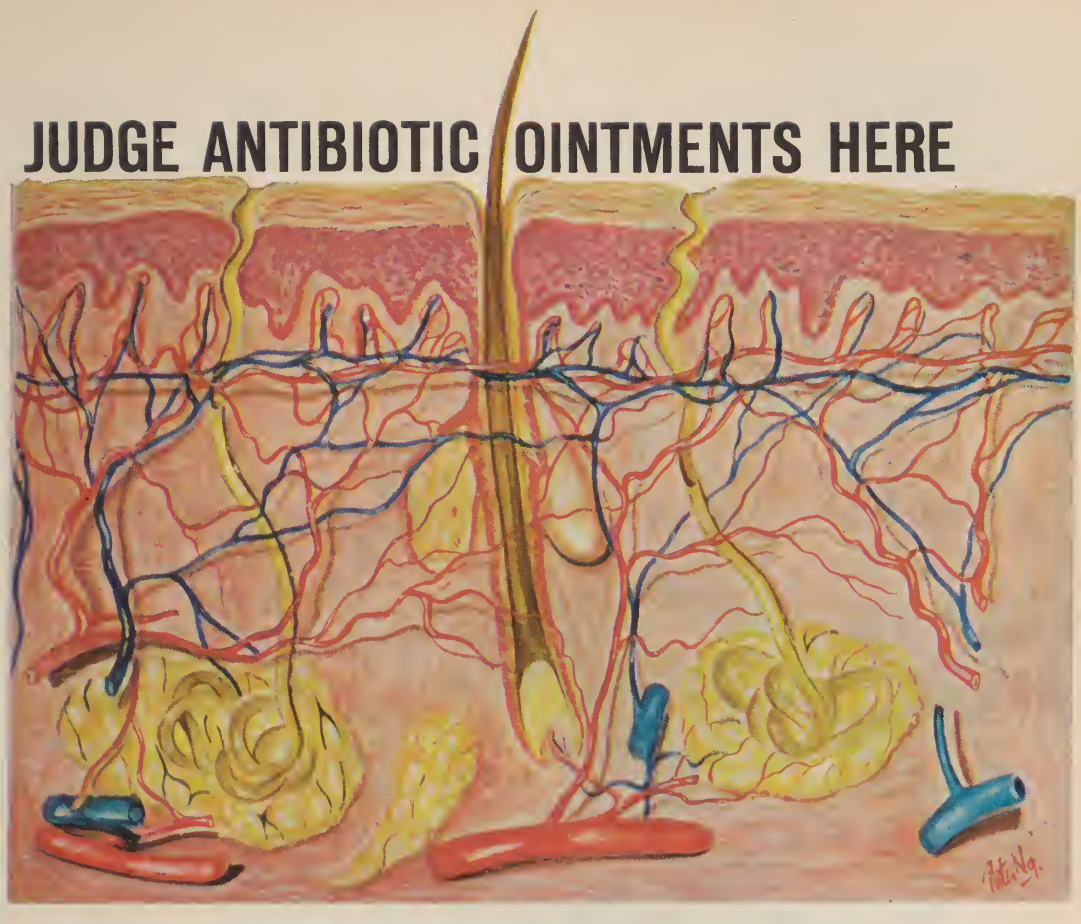
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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.



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ROBERT E. FARBER, MD, MPH, COMMISSIONER

Baltimore City
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The Future Aspect of Child Health Care in Baltimore

You have heard about an era, now gone, that is recalled with nostalgia by those of us who remember it well. There were poor and incompetent folk among us then. Their proportion to the total population may have been as great then as it is now, but there did not *seem* to be as many, nor did their plight appear to be so tragic.

ALEXANDER J. SCHAFFER, MD
Associate Professor Emeritus of Pediatrics
The Johns Hopkins University School of Medicine
Assistant Commissioner of Health
Baltimore City Health Department

In those days, man *was* his brother's keeper, mothers and fathers raised and shepherded their young until they were able to negotiate the hazards of the cruel world on their own; and when parents were lacking, grandparents and uncles and aunts felt duty-bound to act as surrogate fathers or mothers. Charity there was, but it was a personal kind of amateur philanthropy. The Babies' Milk Fund was among the first of these benign agencies which performed to the dictates of warm hearts rather than of cold brains. In latter years, much of this has changed. The clan is no more. It can no longer shelter its own incompetents and bring to heel its backsliders. Sweet Charity has given way to Welfare; governmental agencies have tried to replace blood ties and friendly neighbors; and the pastor has been shouldered aside by the psychologist, psychiatrist and policeman.

The State has not succeeded in filling the hiatus left by the disintegration of the clan. What can we do to bridge this chasm?

The following prophesy is personal and does not necessarily represent the visions of the Baltimore City Health Department or its Commissioner or Deputy Commissioner.

I see the streets and the many parks which will dot the inner city, full of happy children. Mothers will be pushing carriages and perambulators in which all the babies will be plump and firm, their skin pink, their mucous membranes a deep rosy-red. The older children will be tall and well-muscled. This will be in glaring contrast to our present population of children, of whom X times as many as should be are small and underweight, and most of whom are pallid because of the reduced hemoglobin content of their blood.

I see new modern schools here and there, with playing fields of grass, not asphalt, and bordered, in the appropriate seasons, by gay annuals and

Presented at a conference on May 10 at Maryland General Hospital. The conference, The Development and Future of Maternal and Child Health in Baltimore, was sponsored by the Baltimore City Health Department, Maryland General Hospital and the Maryland State Department of Health.

perennials. Within the school, the classrooms are large, bright, and airy, and the classes contain no more than 20 children each. These schools are open all day and all evening, and are utilized for many purposes.

And I see adjacent to each of these schools, every square mile or so, a building or a group of buildings nestled within the same grassed and treed areas. These are Community Centers. Each center will contain all the needed facilities, and will be staffed by enough physicians, dentists, nurses, social workers, sanitarians and paramedical personnel for total comprehensive care to all the families of the neighborhood. There will be no more categorical services, such as those exclusively for children, like Well-Baby Clinics and School Health Services; or for adults, like Cancer, Heart and Stroke Programs, or for the old. The *family* will be the operative unit. There everyone, rich and poor, white and black, young and old, sick and well, will receive all of his preventive and therapeutic care short of that which requires hospitalization. Here pediatricians and internists and their trained lay assistants will perform all the supervisory and prophylactic services required; will test and retest at appropriate intervals growth and development, both physical and intellectual; and will keep a sharp eye upon developing social attitudes.

All the screening of well babies as well as adults, and much of the continuing care of those with chronic illnesses will fall within the province of specially trained nurses or laymen, not physicians. At any sign of deviation from the normal, all the resources within the center will be brought to bear upon the straying lamb and his family.

Within the same center will be large, airy rooms in which infants and children from the ages of two months to five years lie in cribs and playpens, toddle or run about, play with simple or more intricate toys, putter in sandpiles and draw or paint upon blackboards and easels under the watchful eyes of cheerful, gaily-smocked older children and adults. Out-of-doors are wading ponds and pools where other children splash, and sail boats, while in the shade of leafy trees, sit and loll groups of others to whom bright-faced girls are reading or telling stories. We will not perpetuate the mistake of waiting until our children reach three or four years of age before assuring them plenty of warmth and stimulation, for we know that by then, irreversible damage may have been permitted. There is little point to trying to Head Start after the brain within that head has been stunted. At the sound of a bell tables miraculously appear, indoors and out, are covered with food from America's inexhaustible granary, carried out from the gleaming kitchens where it has been tastefully prepared.

In the evenings the center is again filled, now with teen-agers and adults. Now the rooms are utilized for continuing education, and for recreational activities—dancing, reading, arts and crafts —and discussion groups, drama and whatnot. Trained counselors are available to all for advice. Group discussions are held concerning health care, family planning, and the special difficulties of adolescents. Individual attention is given to one or both parents when specific problems present themselves. The disbursing agent may decide that funds—over and above the minimum annual wage underwritten by the government—are needed for this emergency situation, and these are promptly made available.

These Community Centers are purposely not called Health Centers. It will be recognized in those enlightened days that an individual's health at any one moment is not an isolated phenomenon, but is initimately bound up with the status of the health, economic security and emotional stability of his parents, and of his cousins and his sisters and aunts, and of decency and the dignity of the total community of which he is a part.

In my crystal ball I see the hospital as no longer the prime agent for delivery of health care, but as the source of ideas and of personnel and as the controlling arbiter of the quality of health care supplied by its satellite Community Centers. I see it, too, as a warm place where children must go for more serious intervention, and where every child who must be admitted may have his own mother beside him much of the day and night, and where his own medical and paramedical friends from the Community Center visit him freely and take an active part in his care and rehabilitation.

These dreams have arisen from the conviction that the business of making a good adult and a good parent begins at birth. The fundamental needs of the newborn, the infant and the child encompass a dignified uncrowded home, perfect nutrition, a plethora of adult warmth and a life replete with intellectual stimulus and challenge. This seems simple enough. God grant us and our legislators the breadth of vision and the determination to move forward promptly toward this goal. Tomorrow may be too late!

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Maryland State department of health

HIGHLIGHTS

New Day-Care Regulations Under Consideration

Revised regulations governing the operation of day-care centers for small children, under consideration for three years, were presented at the June meeting of the State Board of Health and Mental Hygiene, by the Division of Maternal and Child Health.

Article 43, Section 707, of Maryland's health laws, declares the State's policy to be that "the condition of childhood is such that the child is not capable of self-protection, and when the child's care is given over to others, certain mental and physical risks arise, calling for reasonable protective measures to offset these risks."

Governor Tawes' Commission to study day-care services for children found that present regulations do not safeguard the social, emotional, and intellectual development of children receiving day care, and recommended they be revised to correct these lacks. The suggested revisions would provide the Health Department with a tool for upgrading existing day care centers, and legal grounds for prevention of the development of any new centers which might perpetuate handicapping situations for young children. Major changes proposed would affect licensing procedures, staffing and space requirements, group size, minimum age, record keeping, planned programming, and environmental protection.

Statements supporting the proposed regulations were made by Alexander J. Shaffer, MD, Maryland Chapter of the American Academy of Pediatrics; Mrs. Sadie Ginsberg, U.S. National Committee for Early Childhood Education; Stanley A. Hoffberger, President, Maryland Committee for Day Care for Children; Baltimore Municipal Court Judge Robert Watts, Member of the American Civil Liberties Union and NAACP; Matthew Debuskey, MD, member of the Advisory Council on Preventive Medicine and Chronic Diseases; Mrs. Richard Lansburgh, President, Day Care and Child Development Council of America; Ted Muellen, PhD, State Department of Education; Mrs. William J. Tretbar, President, Board of Parole Community Day Care Center, Inc.; Miss Mary Elizabeth Hoff, Supervisor of Federal Programs, Board of Education, St. Mary's County; Mrs. Marian Haynes, representing 150 mothers of the Baltimore Chapter, Jack and Jill of America, Inc.

The Board voted to accept the regulations for consideration and review before taking final action.

New Family-Planning Record System in Operation

After three months of successful pre-testing in Anne Arundel County, a new computerized system of record keeping for family-planning patients was initiated July 1 in all county health department clinics, except for Montgomery County, which plans to enter the system October 1. The new method of statistical analysis places appropriate importance on the number of patients actively practicing birth control as a result of the program effort. In addition, the system will complement existing follow-up procedures by quickly identifying delinquent and inactive patients. Initial cooperation has been most gratifying.

Walter N. Kirkman Dies

Walter N. Kirkman, former State purchasing agent, budget officer, Budget and Procurement Director, Secretary of the State Board of Health, and member of the Board of Health and Mental Hygiene, died July 8 at the age of 82. Honored many times in many ways during his lifetime, Mr. Kirkman is mourned by a host of friends and acquaintances.

To name only a few of the important functions he has performed, he assisted in the organization of full-time health departments in each county of Maryland; later served as chairman of the commission which planned a system of chronic disease hospitals for the State; for 13 years was director of the Medical and Chirurgical Faculty, whom he represented before the General Assembly, and by whom he was accorded honorary membership; was instrumental in establishing the predecessor of the Maryland Port Authority; and was a member of the Committee on Medical Care of the State Planning Commission.

Most Laboratories Eager to Comply with New Law

Prior to July 1, the effective date, all laboratories received a copy of the new law requiring them to report to the Division of Communicable Diseases positive results of examinations for syphilis, gonorrhea, and tuberculosis. They were also given report forms, self-addressed postage-paid envelopes, and a communication from the Commissioner explaining the method of reporting.

Although the law does not require patient identification by name, only one laboratory has used a code number instead. In the three weeks since the law became operative, reports have been coming in at the rate of about 150 a week, with syphilis serology in the majority.

In the first two weeks, 12 tubercle bacillus-positive examinations were made on sputum specimens from individuals not previously known to the Health Department as active cases.

Billing Instructions Revised for "P" Card Holders

Following the economy measures ordered by the Governor in the Medical Assistance Program, revised billing procedures were developed and instructions mailed to all participating physicians. The changes apply only to patients certified as medically needy, not to those receiving public assistance payments as part or all of their regular income.

The medically needy, identified by the letter "P" (for Pay) following the certification number on the Medical Assistance card, are expected to pay the attending or consultant physician $1 for each home or office visit. The Health Department will deduct this amount from its reimbursement. Patients in hospitals or nursing homes are not expected to pay for visits by the physician. No co-payment is required for EEG, EKG, refraction, laboratory services, or X-ray (Service codes 13, 14, 15, 17, and 18 on the MS-4 billing form). Services falling in the category of "other" (Code 19) are subject to the $1 co-payment.

Pending revision of the billing form, physicians collecting the co-payment from medically-indigent patients received authorization to sign the affidavit included in the present form which states that they "have made no charge and will not accept payment from the patient or patient's family . . ." etc.

The indigent patients, identified by the letter "N" (No-Pay) following the certification number, are not required to pay any part of their medical expense.

It is important that the identifying "P" or "N" be included after the 11-digit certification number; otherwise the bill must be returned for proper identification.

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Alcoholism Law and the General Hospital

Governor Spiro T. Agnew will convene a conference of general hospital administrators, medical and psychiatric chiefs, and board presidents on Thursday, September 26, 9:30 A.M. to 4:00 P.M., at the University of Maryland Center of Adult Education in College Park. The purpose is discussion of the general hospital's role in implementing the State's Comprehensive Intoxication and Alcoholism Control Law.

The program includes an analysis of the law by a representative of the Attorney General's office, presentation of Baltimore City and State alcoholism program plans, and a discussion of problems and plans regarding financing general hospital treatment of acute intoxication.

Two out-of-state authorities will speak on professional aspects of the subject: Marvin A. Block, MD, past chairman (1954-64) of the AMA Committee on Alcoholism, on "Medical Treatment of Alcohol Intoxication and Withdrawal Syndrome"; and Nelson Bradley, MD, Chief of Staff, Lutheran General Hospital, Park Ridge, Ill., on "Medical Training in the Alcoholism Field."

Registration fee, covering the cost of lunch, is $6, and physicians interested in registering can do so by application to George B. Trubow, Executive Director of the Governor's Commission on Law Enforcement and the Administration of Justice, 301 W. Preston Street, Baltimore 21201.



Blessed event?

Not entirely, when nausea and vomiting occur in early pregnancy. Emetrol offers prompt and safe relief. Local rather than systemic action provides emesis control on contact with the hyperactive G.I. tract.* In a study of 123 pregnant women, the drug produced measurable improvement in 79% of patients in controlling vomiting.[1]

*As shown by *in vitro* studies.
1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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Emetrol®
phosphorated carbohydrate solution
emesis control

An Aid to Closing the Parent-Child Communication Gap

Sex education and venereal disease are just two of the topics parents hesitate to discuss with children because they feel inadequate to the task. The AMA's new pamphlet, "How to Close the Parent-Child Communication Gap," describes a variety of pamphlets designed to enable parents intelligently to fulfill this educational need.

This brochure describes the AMA materials on sex education, drug abuse, venereal disease, smoking and alcohol. It contains an order blank to facilitate handling and also a "reduced rate" offer for *Today's Health*.

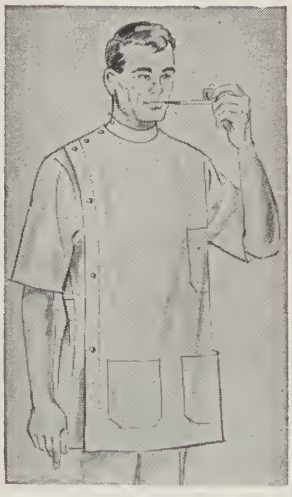
There are seven AMA pamphlets on teaching your children about sex and not one mentions the stork. As a guide to parents teaching their children about the dangers of alcohol, the AMA suggests three pamphlets.

To obtain copies of the brochure listing available materials, just write the AMA Circulation & Records Department, 535 N. Dearborn St., Chicago, Ill.

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Fashion goes Professional in the new 3 button notched lapel coat. Roomy patch pockets add a touch of dash to the modern, slimming silhouette.

#315—in long sleeves only in 65% Dacron Polyester and 35% Cotton Dac-o-Gab

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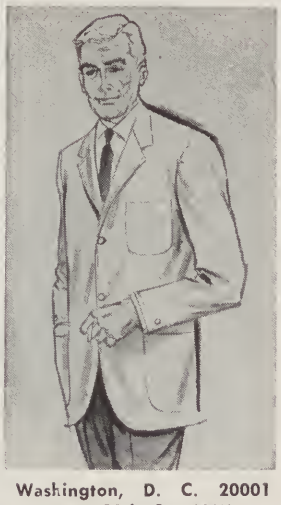
#400—100% Cotton—2x1 Sanforized Poplin **$4.99**

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#604—Short Sleeves 100% Cotton Drip Dri Broshan Slub Sanforized Plus White, Aqua, Blue **$4.99**

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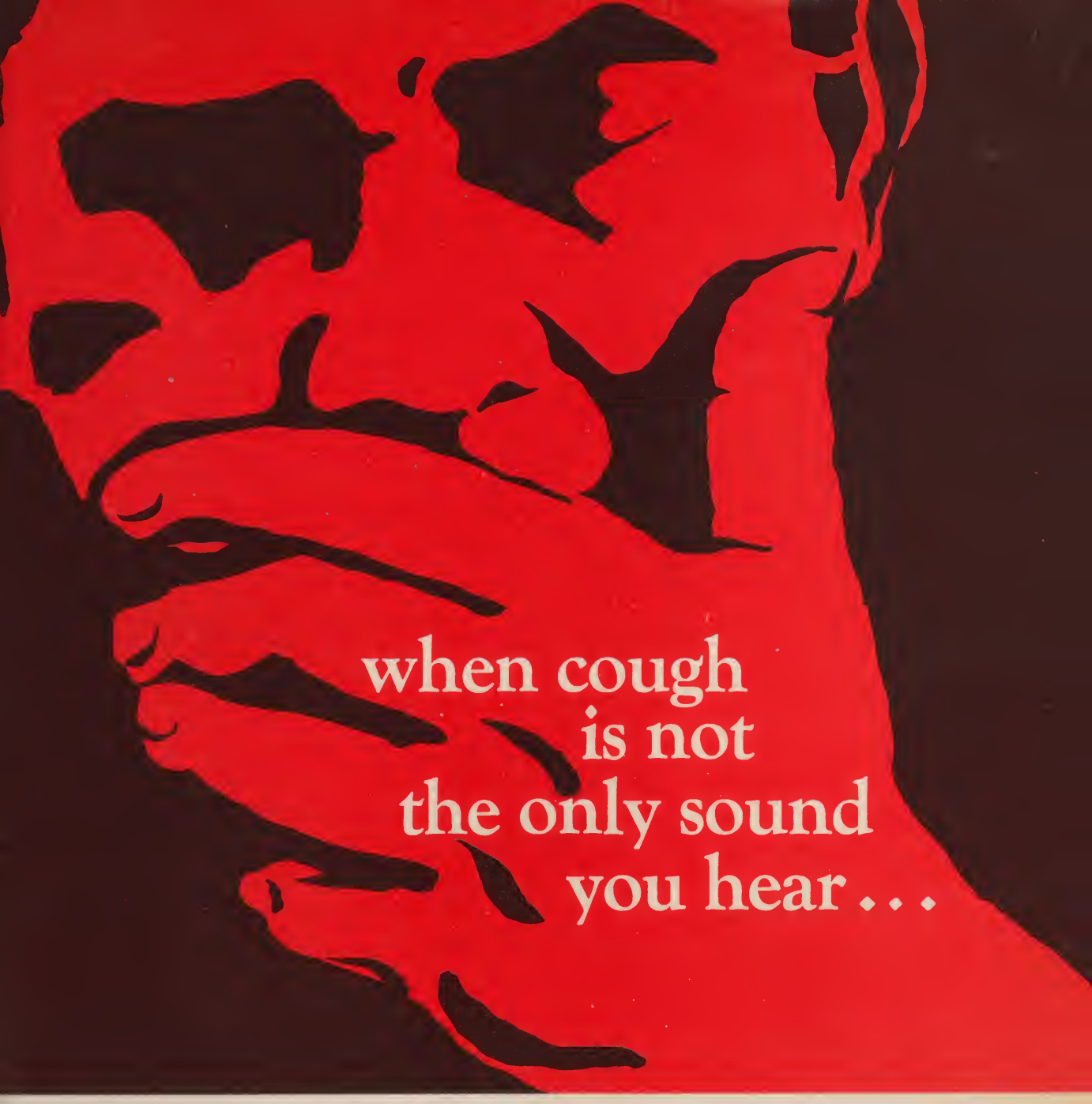


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OMNI-TUSS® b.i.d.

. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

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Wallace & Tiernan Inc., Rochester, N.Y.

new evidence for TAO® (triacetyl-oleandomycin)



a
macrolide
antibiotic for the
frequently seen
respiratory infection
in the office
and
for a problem pathogen*
in the hospital.

*Staphylococcus aureus

study I[1]

Results of a 1967 in vitro—in vivo correlation study involving 116 patients with Gram-positive coccal infections in five institutions. All patients were given TAO prior to determining the susceptibility of the offending organism.

97.0%
of the organisms were susceptible to oleandomycin*

98.0%
of the patients responded favorably to TAO® (triacetyloleandomycin)

*In some cases more than one pathogenic organism was isolated from the patient.

study II[2]

Effect of oral therapy with TAO, erythromycin, and cloxacillin on the survival time of Rhesus monkeys after intravenous inoculations of lethal doses of staphylococci, phage type 80/81.
(8 monkeys in each group)

conclusion:

*Under the conditions of this study and the doses employed, it was found that

TAO® (triacetyl-oleandomycin)

was far superior to erythromycin, as was cloxacillin, a bactericidal agent, and of particular interest, "...bacteriostatic triacetyloleandomycin was as effective or perhaps superior to cloxacillin in preventing lethal (staphylococcal, phage type 80/81) infection."

*It should be pointed out that results obtained in an experimental study of this nature may not necessarily be directly extrapolated to the clinical situation as it pertains to man.

TAO Rx Information

INDICATIONS: Include streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents. **CONTRAINDICATIONS AND PRECAUTIONS:** Not recommended for prophylaxis or in the treatment of infectious processes which may require more than ten days continuous therapy. In view of the possible hepatoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgement dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including darkfield examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug. Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

References: 1. Isenberg, H. D.: Clinical Evaluation of Laboratory Guidance to Antibiotic Therapy; Health Laboratory Science (July) 1967. 2. Saslaw, S., Carlisle, H. N.: Studies on Therapy of Staphylococcal Infections in Monkeys. 1. Comparison of Cloxacillin, Triacetyloleandomycin and Erythromycin. Proc. Soc. Exp. Biol. & Med.: Vol. 125, No. 4 (Aug.-Sept.) 1967.

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In the complex picture of moderate to severe anxiety...



there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl)
25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

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Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension



Enduron: (methyclothiazide) A basic building block for mild hypertensives



Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persists for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

ENDURON®

METHYCLOTHIAZIDE

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

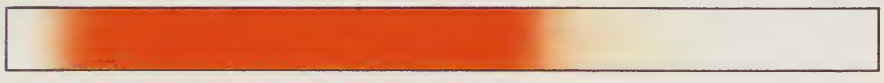
Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

Once a day, every day

ENDURONYL®

METHYCLOTHIAZIDE 5 mg. with DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

801094

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions—Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

ABBOTT

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PAUL F. GUERIN, MD, CHAIRMAN
Library and History Committee
ELIZABETH SANFORD
Librarian

library

Thanks, Senator Hill!

The most outstanding friend of libraries and medicine to realize the fruits of his efforts, Lister Hill, the senior Senator from Alabama, is now retiring after 40 years of public service.

During those years he constantly fought for his ideals and visions of a healthier population through the Hill-Burton hospital program, for better libraries both in the public and biomedical fields, and for other constructive measures upgrading the well-being of the American people.

Since the National Library of Medicine is a prime beneficiary of his efforts, their Board of Regents recently honored him at a gathering to express their gratitude.

The featured address was made by Senator John Sparkman, junior senator from Alabama, who has worked with Senator Hill for twenty years. He suggested that the new annex to NLM be designated the *LISTER HILL CENTER FOR BIOMEDICAL COMMUNICATONS.* Following this, William Bean, MD, presented Senator Hill with a hand-lettered scroll listing his legislative accomplishments. "Scholarship and research have been nurtured at the same time that advances in medicine became more readily available for improving the health of the nation," said Dr. Bean in commenting on Senator Hill's achievements.

Let us hope another legislator as dedicated to the cause of health and libraries will emerge to fill his senatorial seat.

(See *NLM News,* July 1968, for full information)

Pursuant to the above, a new Library exhibit at NLM features *Law and Medicine,* showing significant medical legislation sponsored by Senator Hill, and is dedicated to him.

The theme for the Third International Congress on Medical Librarianship, May 5-9, 1969, in Amsterdam, is *WORLD PROGRESS IN MEDICAL LIBRARIANSHIP.* Mrs. Jacqueline W. Felter, MLA President, 1968/1969, is U.S. liaison representative. Any requests concerning transportation should be addressed to her at:

Medical Library Center of New York
5 East 102nd Street
New York, New York 10029

Registration forms are available from:

Office of the Secretary-General
III International Congress of Medical Librarianship
Amsterdam
The Netherlands.

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(Arranged by author and title)

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MRS. HARRY L. BERMAN, EDITOR

woman's auxiliary

A Highlight of the WAAMA Annual Convention

How Can We Prevent Being Defeated by Success?

PHILIP LESLY, PRESIDENT
Philip Lesly Company
Chicago, Illinois

In our rapidly changing, mystifying world, we all have difficulty understanding what is happening in the minds of other people—and in trying to get other people to understand us.

We are living in what has been called the Age of Rising Aspirations—but it more accurately could be called the Age of Unreasonable Expectations. Everything has gone so well for most of our population in the last generation that expectations now are becoming demands, without thought to what must be accomplished to bring about our next round of bounties.

Marvelous changes have come so fast that many people, especially those who didn't experience the trials of adult life before 1946, now feel "miracles" can be had just by wanting them belligerently enough. This feeling has destroyed the patience and discipline necessary to achieve any real accomplishment.

Our progress in so many areas, and the lifting of many of life's greatest uncertainties, has heightened the great American illusion of perfectability. Many people now want instant transmutation of what *should* be into what *must* be. What *should* be, in a society that has come so far, is presumed to be an immediate goal, namely: the perfection of mankind.

Medicine, particularly, is faced with the problems created by its own success. Until our own generation, man lived with certainty that death could strike at any time. Good health was the most uncertain of all our blessings. Now that science and the medical profession have made great strides in holding off disease and overcoming maladies, all our people urgently want what medicine can offer. There is no subject more capable of arousing emotions than life and health; and now people demand that the best medical care be *given* to them, care far better than their fathers could have bought with all the wealth of the Indies, and they demand it by coercion, if necessary. Of course, this is unreasonable in light of what is available to meet the needs and the time and effort it takes to catch up with such surges of demand.

So, medicine is faced with some problems, created by its own success that are far greater than the problems it faced when it could offer so much less in knowledge and healing skills. Success brings improvement and improvement automatically creates change.

When we succeed, change challenges our successes because the patterns that led to our success no longer fit the bright new conditions we create.

The great problem of our age is how to create change, how to live with change, how to *direct* and *master* change so that it will not overwhelm us and destroy the fundamentals that made our success possible.

One of the striking features of the changing world is that everything is becoming more complex. Each of us has so many more things that we must know about or cope with. At the same time, each of the things we deal with becomes more complicated and we understand it less. Practitioners in every field face more and more they must know. At the same time, the rest of the public is overwhelmed by the number of complex things it must face. We have an "understanding gap" between the segments of our population that is at least as serious as any credibility gap.

Complexity has been marked by a move toward a corporate society. Today, more than 90% of all earners work for someone else. This includes many professionals such as engineers, architects and teachers. These people are on salary and find it difficult to understand why this is not a satisfactory state for everyone—even physicians. A special and difficult challenge faces the medical profession, to educate this public on why there is such a great difference in medical service; why for most physicians, the absence of institutional shackles has such a great influence on their ability to provide good care.

At its best, public relations is a bridge to change. It deals with the problems of communication between changing groups that are rapidly being made different from each other.

It provides to every organization and group the vital benefits of objectivity, of being able to see the whole of our society together, rather than from one intensified point of view.

It provides judgment, creativity and skills in accommodating groups to each other, based on wide and diverse experience.

By the relentless sequence of our era, then, success creates change, change creates new problems, and success is always in danger of turning into failure. For example, the high rate of automobile accidents results from the progress of the automobile, and in turn threatens our entire system of automotive transport. Our success in creating a cornucopia of plenty through mass production and industrial development creates pollution and congestion that can strangle our entire society. Our creation of fabulous cities with glittering attractions poisons the body and the spirit and threatens to make wastelands of the very wonders we have built.

We now have a population with more years of education than any people have ever had. But this success has also created problems: Almost everyone has the "little learning" that Alexander Pope said was a dangerous thing. People feel they can form judgments with too little knowledge.

In medicine, people now know just enough to be demanding and critical, to expect too much. Where they used to suffer in ignorance or medicate themselves, they now feel they know enough to determine how medicine should be practiced.

Some of our problems are due to over-successful building of "images." The image of the dedicated personal physician as the apotheosis of human service now blocks the public's acceptance of specialization and treatment in the office and the hospital. The image of the devoted college professor with his students grouped closely around him stands in the way of modern mass education. And the image of America as dauntless and omnipotent leads people to expect our government to do everything, from running a local health-care center to policing the entire globe. The world has changed fast and drastically, but these images have been so well projected they now plague us.

Additionally, everyone is trained in one generation and must function professionally in the next. This means he automatically tends to pursue the direction of his training a generation late. What used to take a generation to change, now often changes in four or five years.

All people want to be in command of the things they know and feel strongly about. At the same time each of us sees so many things that are out of whack and need to be changed, we all tend to steer a familiar course in those areas we know best. Ministers seek to change the ways of everything in the world, except the management of their own congregations. Editors and writers crusade for recasting all aspects of our life, except how their publications are run. Educators are impatient with the workings of society, except for how they teach. Many physicians have a tendency to diagnose the ills in many aspects of society, but to resist any changes in their own practice.

While each group holds to its proved traditions, all depend for their progress on changes that can be brought about only through various forces pressing against the comfortable old ways of other groups.

In the health field, we find these forces very striking. The trick is to guide and direct this

changing profession in orderly evolution, to avoid having it taken over by the most ponderous, the most wasteful, the least professional factor in the health-care spectrum—the federal government.

When individualism, overcoming obstacles through strong will and personal dedication, was the pattern of society, the physician was peerless.

But now that everything is much more complicated, complex organizations and structures are needed. So our society honors the master of complexities, the man who can make things work in vast companies, big government, huge religious groups, and so on.

Further, in all history the character of the times has determined the type and character of those who rose to be leaders. Now instant electronic communication and mass public awareness reward the person with charisma, who projects what people respond to, who creates the vibrations of the public's concerns and then pitches his goals in tune with them.

Thus this is an age, not of the hero, but of the "operator." Physicians, who must be dedicated to the highest fruition of personal abilities and integrity, are in danger of being overrun by the new pattern while they hold to the standards of the hero individual. The medical profession must find ways to bridge this gap, to meet both needs.

In this situation, we must stoically assess what needs to be done and devote the well-known dedication of medical people to doing these things.

First, the profession must be sensitive to public attitudes and vicissitudes so we can keep abreast and ahead of changing aspirations and pressures. It must motivate actions to continually improve our health-care system. These will put the medical profession onstream with the desires of the public. It will make medicine the master, rather than the victim, of change.

Then, we must master the extremely complex factors of modern communications to gain understanding and acceptance for these constructive actions.

Communication, too, was much simpler a generation ago. Only a small percentage of the populace was alert to public affairs. A few magazines and a few major newspapers constituted the important communications network. Today we have an explosion of media.

Any communication that appeals to most groups is certain to repel others. It is no longer possible to have rapport with all the people, we must choose which groups we seek to reach.

Now that almost all the people are impressed with how much medicine can do for them, it is no longer a cloistered science to be viewed only by practitioners. It is part of the consequence of medicine's success that it now faces constant exposure in the public media, in considerations of many groups, and in government. We now must accept the fact that medicine and health-care will constantly be spot-lighted, often erroneously and unfairly; like other all-pervasive subjects, it is now in the public domain.

We must understand the psychological factors of motivation as they apply to medicine's publics: the patients, the media, the pressure groups, politicians, government. To be tuned in by people, you have to be broadcasting on *their* wavelength. Decisions and actions we make must be based on understanding *their* points of view and aspirations —"getting inside their skin"—rather than on our own backgrounds and points of view. You must get onstream with their attitudes and direct what you have to say along their channels, if it is to be accepted and motivate them.

The forces that have made medicine the constant concern of all Americans have also changed the role of physicians and their wives. When medicine was a cloistered subject for consideration only by professionals, physicians were looked on as cloistered men on pedestals. Now that medicine and health-care are so much in demand that they belong to everyone, the professionals are in the arena of everyone's consideration.

Women are potentially one of the greatest forces in America. Women today not only rock the cradle, but rule the polling places, the communications media, the schools and certainly the homes. They are educated, informed people in an age in which education and information are the cutting edges of change. Women can know and understand the role of the physician in today's complex health-care picture; can express it, and exert its influence for orderly progress.

Women must become activators and leaders, not on behalf of a system that existed before medicine brought about so much change, but in order to forge a system in which unshackled medicine can perform the new wonders it is capable of.

Women must use initiative *for* the type of system that will meet the public's need and the physicians' too, rather than merely react to accusations.

What are the gaps in understanding of problems that lead to so much readiness to follow the pied pipers of conscription medicine?

First, people don't realize that one of the biggest

weaknesses in American health-care system is *the patient.*

Medicine is blamed too much for infant mortality, heart attacks, cancer and accidents, most of which Americans bring on themselves by ignoring advice of physicians, carelessness and by intemperate eating, drinking, smoking; and avoidance of exercise.

Second, health-care today is a *system* with *many* elements, not just the physician with his black bag and a few nostrums. It includes the physician, the patient, the medical school, the hospital, many auxiliary personnel, the nursing home, the insurance company, drugs, sophisticated equipment, the atmosphere we live in, the public attitudes, dollars, and the government.

As in any system, all of these factors are interrelated. They must develop *together.* If any of them gets too much push, all of them are likely to get out of whack. Too many patients all at once, too many dollars pumped in, major changes in any part of the pattern create intolerable stresses in the rest of it.

Third, people tend to see "health-care" as meaning the medical profession, and that is interpreted as being the physician. Because of the physicians' visibility, prestige and leading role, they are blamed for the problems of the medical schools in failing to enroll more students, of the hospitals for their soaring costs, of the drug manufacturer, the pharmacists, the nurses, the insurance companies, the super-imposed government health centers and other factors they have little control over.

The *separate* responsibility of the physician must be stressed. The efforts of the most responsible doctors to keep fees reasonable, to make efficient use of hospitals and other resources, to concern themselves with cost of drugs and so on, must be demonstrated.

The women must help the health-care system to work better. They should take active part in the Auxiliary's programs, such as the "Package Programs" of public health education on such matters as careers in the health field; immunization, youth health and fitness; and the blood program. These show that local private factors can make progress against the stubborn and underlying problems of community health. They should be sure the medical profession gets credit for these things they do. They should recruit support from other wives and from laymen and press for improvements that will overcome criticism of the profession and help make the system work better.

Women should become opinion leaders on behalf of a balanced, sound approach to the advancement of health-care. They should explain, educate, and answer questions in the church, with the local press and broadcast media and in politics.

This is a critical political year. Never was there so clear a chance to make oneself felt as a citizen. To do less than your best is to turn over the fate of the country and of medicine to those who understand them less.

It is difficult for busy physicians to keep up with the increasing complexities of the non-medical world. The women can be their eyes and ears, screening the masses of information and opinion for them and expressing their points of view and judgments back to the community.

Women are stabilizing forces and powers for good when they assert themselves. They should urge enforcement of the highest standards of ethics and practice that will justify medicine's claim to being best able to direct the health-care of the American people. The formidable talents and determination of the women will leave their mark on the future.

A Day at the Races!

Reserve Wednesday, November 6, 1968, for AMA-Education Research Foundation Day at Laurel Race Track. Ten dollars includes an elegant buffet luncheon in the Clubhouse. Doctors are welcome. For reservations contact Mrs. Elmer G. Linhardt, 3 Chesapeake Avenue, Annapolis 21403.





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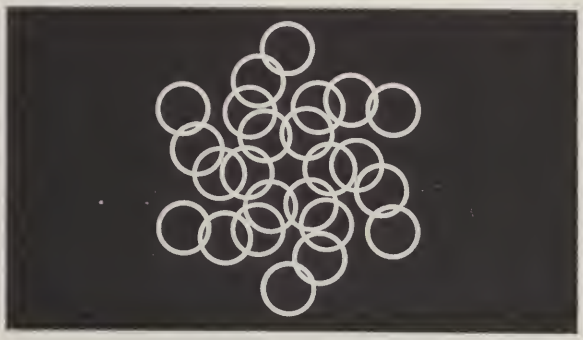
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Niacinamide	50 mg
Calcium pantothenate	10 mg
Ascorbic acid (Vit. C)	300 mg





From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

Detoxification of the Alcoholic Patient

Effectiveness of Thioridazine in Routine Therapy

The "drying out process" or "detoxification" of the alcoholic patient is the vital first step in *all* approaches to the rehabilitation of alcoholics. Social and legal attitudes toward the "problem of alcoholism" today are in an exaggerated state of flux. The debate currently seems to center on whether an individual drunk—on a city street, in a private home, in a crowded theatre balcony, behind a steering wheel, flying an airplane, or even waving a gun—is a *sick* person or a *criminal* person. Fine points of sociological and legalistic arguments, however, are not appropriate considerations for members of medical teams responsible for returning the drunk to sobriety and to society once more.

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Sobering up is not a simple process notwithstanding the easy assumption that when 'detoxification' is over the individual is ready for rehabilitation. Return to sobriety is not a smooth path. It is no push-button business. Progress has been made since the 1930's when from 20% to 40% of patients with delirium tremens in hospitals died. They died of exhaustion, pneumonia, convulsions, cardiac failure, or just plain "complications". Progress made in the 1960's has evolved a method of treatment with less than 1% fatality in the same population. The method of treatment is reported here in the hope that it may be of assistance to others with a similar problem.

Perhaps nowhere are the results of alcoholism more clearly and frequently seen than in a city jail. It seems paradoxical that withdrawal of the offending agent should produce effects that are such a profound strain on the alcoholic and challenge to the attendants. Care of the alcohol withdrawal syndrome makes heavy demands on the personnel who tend patients with the Spartan resources of a city jail. The large number of patients and the small number of attendants emphasizes the magnitude of the problem. Table I shows the total committed to the Baltimore City Jail between 1957 and 1966 together with the number of alcoholics sick enough to be admitted to the Jail Infirmary since we began to keep records in July 1963.

Alcoholics are about 16% of the commitments. The majority are deteriorated, often repeaters. They have lost all home and family ties and sunk to the state of skid row bums. They earn drinking money by panhandling, odd jobs, or thievery. Their cravings are such that they drink

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anything that pours including cheap wines, hair tonic, antifreeze, solvents, and even Sterno. Alcohol has become their way of life, except when it is denied them in a jail or hospital.

TABLE I

	Commitments to the Baltimore City Jail	Alcoholics Admitted to Infirmary
1957	19,915	
1958	19,688	
1959	18,100	
1960	19,462	
1961	19,200	
1962	21,201	
1963	20,626	1,731*
1964	22,474	3,044
1965	26,164	4,802
1966	19,936	1,648*
		11,225

* Six months only.

A smaller number are alcoholics who may be usefully employed for periods between bouts of alcoholism, drunkenness, and jailing. Ties with family, friends, church, or job provide hope of rehabilitation through Alcoholics Anonymous.

Delirium tremens may occur as late as 5 to 7 days after withdrawal. Alcoholics brought to the Jail Infirmary almost invariably have it or are on the verge. They are tremulous, hallucinating, violent, noisy, confabulating, disoriented and it may take several helpers to support them, wash them, and put them to bed. There are other sick patients there too. With the large number of alcoholics coming in daily, the method of treatment needs to be extremely practical and speedy.

The *first* treatment step is to quiet the patient's psychomotor activity—to give him safe sleep. A stat dose of paraldehyde is given, orally if possible, parenterally if necessary. This permits examination for complications: head injury, fractures, burns, infection, arrhythmia, marks of addiction, cards indicating history of epilepsy, diabetes, and the like. Thereafter the patient is restrained in bed as needed to prevent harm to self and others. Personnel shortages and crowding require restraint more than seems necessary in other types of hospitals. Table II outlines the treatment method that has evolved here as the most successful to date.

TABLE II

Routine Orders for Treatment of Alcoholic Withdrawal Syndrome

1. Bed rest.
2. Paraldehyde 15 ml in 15 ml aromatic elixir p.r.n. on admission. (Rarely 5 ml I.M.)
3. Turn patient from side to side every hour. Do not allow patient to sleep supine.
4. Thioridazine (Mellaril), 100 mg twice a day for 2 days, then 50 mg three times a day until eating well.
5. Offer fortified milk drink (Meritene) every hour until able to take regular diet. Encourage patient to take as much as he can tolerate.
6. One multivitamin and mineral capsule (*"Maintenance", not* "Therapuetic") twice a day.
7. Thiamine hydroehloride 100 mg orally every 8 hours.
8. One "A.M. Capsule" * in morning and one "P.M. Capsule" * in evening for 4 days.
9. Digestive supplement (Panterie) 0.3 gram twice a day.
10. Cyanoeobalamin (Vitamin B12) 100 meg daily, I.M.
11. Antieonvulsants for seizures, present or known.

* Each *"A.M. Capsule"* contains calcium pantoethenate 10 mg, magnesium hydroxide 250 mg, and magnesium sulfate 250 mg. Each *"P.M. Capsule"* contains calcium pantoethenate 10 mg., magnesium phosphate 250 mg, and magnesium sulfate 250 mg. (These capsules are prepared for us by a local pharmacy.)

Treatment

The essential aim of this treatment regimen is to control psychomotor exhaustion, replenish fluids, electrolytes, and vitamins, and to prevent or relieve concomitant illness, trauma, or complications.

Psychomotor Agitation

Psychomotor agitation is an immediate danger, for, if left unchecked, it leads to muscle exhaustion, hyperpyrexia, and death. Aspiration pneumonia and traumata are the common serious complications of the alcohol withdrawal.

In this Jail a number of compounds, notably barbiturates and then tranquilizers, have been used to relieve agitation and their effectiveness observed. Limiting factors are the comparative efficacy, safety, and ease of administration and safekeeping.

The advent of tranquilizers was a great for-

ward stride. They were potent and without addiction potential. Promazine (Sparine) proved effective when administered parenterally, but its hypotensive potential was considered too great and it was abandoned. Chlordiazepoxide (Librium) given orally or parenterally did not control cases of this severity.

Reports [1-3] that thioridazine (Mellaril) was as effective as other phenothiazines with fewer side effects, notably hepatotoxicity, brought it to our attention. Its effectiveness and safety have been borne out in the treatment of more than 11,000 patients over a three year period. No case of drug-associated jaundice has been encountered. There have been noted little or no extrapyramidal symptoms or dulling of sensorium. More positively, thioridazine has been routinely effective in relieving or lessening agitation, tremulousness, hallucinations, in removing the anxiety which is a concomitant to the disturbed state of the alcoholic, and in permitting sleep, in conjunction with the therapeutic regime.

Fluids, Electrolytes, Vitamins

Almost every alcoholic patient has an essential nutrition deficiency problem. During periods of drinking, sometimes of weeks duration, alcoholics give little thought to food. On admission they are profoundly undernourished and generally debilitated. Symptoms of "diarrhea, dermatitis, and dementia" are reminiscent of pellagrous patients of the 1920s.

Parenteral fluids are not available in the Baltimore City Jail. Feeding with a fortified milk drink (Meritene) is offered hourly until the patient can take solid food and Jail diet. This gives the hydration so necessary and probably significantly contributes to survival. Meritene supplies electrolytes and protein which are supplemented by multivitamin and mineral preparations.

Complications, Disease, Trauma

During the infirmary stay, patients are under frequent observation to detect complications, especially cardiac failure. This may be a result of the psychomotor activity and exhaustion that has been known to terminate in sudden cardiac collapse. Aspiration pneumonia occurs all too frequently so that strict attention to turning sleeping patients on their side every hour is given, and sleeping supine is prevented.

Obvious traumata usually have been tended in a hospital accident room before transfer to jail. Inapparent lesions and infections are often first manifest in the shower on admission, or when sought for on failure to respond to therapy. Reports on X-rays are sought, but there is difficulty obtaining a signed release from or for an unconscious inmate.

Thiamine deficiency is a major factor in alcoholic neuritis[4] and in Wernicke's syndrome.[5, 6] It can produce cardiac weakness with dyspnea, tachycardia, palpitation, and ECG changes. Full blown beriberi hearts are rare. Evidence[4, 6] that thiamine relieves these conditions led to its use in our treatment program.

Pantothenic acid deficiency has also been implicated in alcoholic neuritis[7] and calcium pantothenate was added to our regimen. Leevy et al[8] presented evidence that it helps in the recovery from alcoholic neuritis.

The role of magnesium in the treatment of delirium tremens was reviewed in great detail by Clough.[9] Studies cited showed that the delirium and gross muscle tremors, the manifestations of both low serum magnesium levels and delirium tremens, were promptly relieved by appropriate magnesium therapy. More recently Caddell[10, 11] presented provocative evidence suggesting a relationship between malnutrition generally and findings of magnesium deficiency. This would appear to have relevance for the alcoholic who also has malnutrition and hypomagnesemic symptoms e.g. tremors, anorexia, hypotensions, insomnia, and neurological changes. Their data suggest that magnesium replacement therapy in alcoholics is more important than heretofore judged. Our experience has established that magnesium salts relieve the symptoms without any laxative effect.

Pancreatitis is apparently common in chronic alcoholism for it is a featured finding at autopsy. It appears to be related more to malnutrition and inadequate vitamin A than to excessive ingestion of alcohol *per se*. Regular dosage of pancreatic extract tablets are given on empirical grounds. Perhaps, also, a lipocaic effect is achieved that permits liver glycogen storage and buffers hypoglycemic episodes.

Vitamin B-12 deficiency has been implicated as a cause of neuropathy [12] and may occur due to malabsorption caused by damage to the gastric mucosa and lack of production of an intrinsic factor. Such gastroenteropathy and neuropathy are relieved by the parenteral injection of cyanocobalamin.

An interesting finding has been the number of patients in whom Parkinson's syndrome is recognized after recovery. At first attributed to medi-

cation, it was found not to be drug-related. Intoxication and trauma have been implicated as etiologically significant in parkinsonism.[13] But one wonders if parkinsonism, undetected, may not be a more significant cause of alcoholism and trauma. The increased muscle tone preventing a protective gesture on the one hand, and insidiously destroying a skill on the other. The syndrome, increased muscle tone, cogwheeling, mask facies, tongue tremor, and the most distressing insomnia have responded to benztropine (Cogentin) given at bed time.

Anticonvulsants are given to patients with seizures or known to be epileptics able to take diphenylhydantoin (Dilantin); antibiotics to those with infections and fever. Patients with cardiac insufficiency that does not respond promptly to thiamine are given gitalin (Gitaligin) and magnesium capsules are omitted from their routine. Critically ill or traumatized patients are transferred of necessity to other Baltimore hospitals and are lost to follow-up and statistical study by us.

Discussion

Methods for treating the alcoholic during the withdrawal phase are many and varied. The immediate causes of the complications of withdrawal and best treatment for them is a matter of debate. While controversy continues, a system of treatment, based on extensive use, on effectiveness, and on freedom from toxicity has much to commend it. The "Routine" presented here qualifies by these criteria. It has been used in the treatment of more than 11,000 patients in a three year period. It has reduced the mortality of alcohol withdrawal substantially. Recovery from symptoms and signs has occurred within two to four days, on the average.

The relative importance of each component is difficult to assess as each patient is different from any other. The use of each of the measures and medications is warranted by reported evidence that each one has been shown to have influenced favorably some aspect of delirium tremens. The control of agitation by thioridazine which has been consistently demonstrated seems to give it major credit in making the rest of the treatment possible and in reducing the number of complications and deaths formerly associated with the withdrawal syndrome. The use of thioridazine has been marked by a lack of adverse reactions and notable absence of jaundice.

The dose of thioridazine has been determined by trial as the one usually sufficient to control agitation without side effects. The balance of tolerance and efficacy was reported by Smith and Swanson.[14] Safety and freedom from reactions is particularly important in a jail facility where security requires one to three locked doors separating medical personnel in their stations and the patients for whom they are responsible but whom they must visit singly. Hayman[15] also has described thioridazine as one of the principal drugs which has stood out in its usefulness in the management of alcoholism and its complications. Its oral effectiveness is especially useful.

No program or routine can be effective without implementation by the staff. The superior nursing care given by senior, experienced nurses and by the inmates under their direction is a major element in the success of the treatment program.

Summary

A program for the detoxification of hardcore alcoholics is presented. In the period July 1963 to June 1966 over 11,000 alcoholics in the acute withdrawal phase have been successfully treated by this method. It relies principally on thioridazine for tranquilization and control of agitation and excitement during the drying out process.

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DOUGLAS G. CARROLL, MD, EDITOR

rehabilitation notes

Measurement of Performance in Rehabilitation

ORIENTATION

"In a word, medical statistics relate to the usage of symbols for general references, whether or no the symbolization is correct and the references adequate, rather than to things, occurrences, or happenings. They have no necessary value, other than as analyses of symbol-frequency, unless the relation of the symbols to the reference and of the reference to the referents be agreed *after* that process of discussion, so abhorrent to the medical mind, and so generally stigmatized as unprofitable word-chopping." [1]

The third large area of knowledge needed to estimate potential for improvement in independence (in addition to diagnosis and ADL) lies in the mental, learning and orientation facilities. To evaluate the patient's orientation, the Mental Status Check List (MSCL) in Table I as developed by Lifshitz[2] has been performed on all patients who were able to cooperate. This is a test developed for estimating orientation in elderly patients. It can be administered to all types of people, requires little cooperation, and may be administered by non-psychologists. This test has been well described and standarized. Our studies show that two judges testing the same ten patients have a Spearman Rank Correlation Coefficient of .830 (Table II).

Table III shows the MSCL score obtained on 189 patients referred to the Department of Physical Medicine and Rehabilitaion because of hip fractures. This group includes all kinds of patients with all types of associated diseases, but very few patients had not had surgery and all had some expectation of ambulation. The purpose of this Table, however, is not to examine the MSCL score in patients with hip fracture, but to note the pattern of loss of performance of the test as the score decreases. In the highest score group (41-50) 100% of the patients answered questions I-A, III-A, IV-A, IV-B and IV-C correctly. In fact, these items (except III-A) were answered correctly by all patients who had MSCL scores over 20. Thus patients in this group tend to retain their name and recognition of objects while other functions deteriorate. Even in the lowest group (0-10), these items were retained better than all others. Subtracting serial 7's, recalling the name of the vice president and interpreting proverb VC were all particularly difficult.

Table IV compares the MSCL's in 100 patients with hip fracture, 100 with right and 100 with left hemiplegia. The group with hip fracture did best on the tests. Those with left hemiplegia did next best and those with right hemiplegia did poorest. If the items of the MSCL test are arranged in order of increasing difficulty for each of the three groups, it will be seen that the order is similar in the three groups except for items VI-A and B which are the worse items in right hemiplegia because of paralyzed writing arm.

* This is the fifth of a series of notes on "Rehabilitation of Chronic Impairments in Adults".

In summary, the MSCL includes a number of subtests (orientation, serial subtraction, current events, identification of objects, abstraction and writing performance) which are related to the patient's ability to relate to the environment. Although the exact score is difficult to interpret, a high score is a good prognostic sign for improvement in function, a low score is a poor prognostic sign.

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TABLE I

Mental Status Check List*

I. *ORIENTATION*

Question A. What is your name? (If only first or last name is given the other portion is requested.)

Question B. What is today's date? (If only portion of complete date is given, the other portion is requested.)

Question C. What is the name of this place you are in? (If only a portion of the correct name is given, the rest of the name is requested.)

II. *SUCCESSIVE SUBTRACTIONS*

Question A. How much is 100 minus 3? .....That's right, and how much is 3 from that? ..... Correct! Keep on going, subtracting 3 from what you get each time.

Question B. Now do the same thing taking 7 from 100.

III. *GENERAL INFORMATION*

Question A. Who is the President of the United States?

Question B. Who is the Vice President of the United States?

Question C. Who is the Governor of the (appropriate) state.

Question D. What city is the capital of the United States?

IV. *IDENTIFICATION OF OBJECTS*

Question A. (Patient is shown a watch.) What is this called?

Question B. (Patient is shown a pencil.) What is this called?

Question C. (Patient is shown a ring.) What is this called?

V. *ABSTRACTION OF OBJECTS*

Question A. What does the proverb "A stitch in time saves nine" mean?

Question B. What does the proverb "It's no use crying over spilt milk" mean?

Question C. What does the proverb "The restless sleeper blames the bed" mean?

VI. *WRITING PERFORMANCE*

Question A. Would you please write your full name on this piece of paper?

Question B. Write also the sentence, "The dog chased the cat."

Reasons why MSCL might not measure mental status: Check appropriate reason:

1. Patient comatose
2. Apparently conscious, does not answer
3. Deaf
4. Paralysed in writing arm
5. Refuses to answer
6. Poor command of English language
7. Illiterate
8. Other

* (For scoring see *J. of Psychology*, 49:295, 1960.)

TABLE II

Correlation of total MSCL scores on 10 patients by two different observers.

JUDGE #1=X
JUDGE #2=Y

r_s=Spearman Rank Correlation Coefficient (uncorrected for ties)=.830

Subjects	X	Y
1	26	29
2	50	46
3	37	27
4	24	20
5	17	17
6	13	19
7	20	18
8	14	11
9	18	17
10	30	20
TOTAL:	249	224

TABLE III

MSCL Scores on 189 patients sent to the Department of Physical Medicine and Rehabilitation with hip fractures.

Group Number	41-50 37 (20%) Percent	31-40 61 (32%) Percent	21-30 35 (18%) Percent	11-20 39 (21%) Percent	0-10 17 (9%) Percent
I A – 0					12
2					18
4	100	100	100	100	70
I B – 0		7	38	72	100
1		10	14	20	
2		8	17	8	
3	16	34	17		
4	84	41	14		
I C – 0		2	8	43	94
1		3	6	26	6
2		2	3	3	
3	46	44	43	18	
4	54	49	40	10	
IIA – 0		8	46	74	100
1		15	11	18	
2	5	20	23	5	
3	30	21	17	3	
4	65	36	3		
IIB – 0	3	18	66	84	100
1	8	20	23	13	
3	35	23			
4	22	7	3		
IIIA– 0		5	23	82	100
3	100	95	77	18	
IIIB– 0	40	56	86	97	100
2	59	44	14	3	
IIIC– 0	22	49	86	97	100
2	79	51	14	3	
IIID– 0	3	16	26	59	94
2	97	84	74	41	6
IVA – 0				3	71
2	100	100	100	97	29
IVB – 0				5	65
2	100	100	100	95	35
IVC – 0				5	77
2	100	100	100	95	23
V A – 0	10	34	69	89	100
1	14	27	11	8	
2	30	23	6	3	
3	46	16	14		
V B – 0	3	18	37	72	94
1	8	18	14	20	6
2	14	31	29	5	
3	75	33	20	3	
V C – 0	27	51	70	95	94
1	16	15	14	5	6
2	25	21	6		
3	32	13			
VIA – 0		7	20	38	88
1	3	7	8	18	12
2	3	16	23	13	
3	94	70	49	31	
VIB – 0		16	31	54	94
1	5	8	29	13	6
2	16	31	20	28	
3	79	45	20	5	

TABLE IV

Items of the Mental Status Check List, arranged in order of increasing difficulty. In the parentheses (behind each item number) is the number of patients (out of the total 100) who were unable to answer item. Thus two patients with hip fracture, 42 with right hemiplegia and 8 patients with left hemiplegia were unable to give their name (Item I-A). Although there were marked differences in performance between the different diagnostic groups, the *order* of increasing difficulty of the items was quite similar, except that patients with right hemiplegia were unable to accomplish the writing test as well as the other two groups.

Order of Increasing Difficulty	Hip Fracture 100	Right Hemiplegia 100	Left Hemiplegia 100
1.	I-A (2)	I-A (42)	I-A (8)
2.	IV-A (5)	IV-B (54)	IV-B (15)
3.	IV-B (6)	IV-A (55)	IV-C (16)
4.	IV-C (6)	IV-C (55)	IV-A (18)
5.	VI-A (17)	I-C (59)	I-C (25)
6.	I-C (20)	III-A (62)	III-D (34)
7.	VI-B (25)	I-B (64)	VI-A (36)
8.	I-B (30)	II-A (67)	V-B (39)
9.	III-A (31)	III-D (67)	I-B (40)
10.	III-D (31)	V-B (71)	III-A (42)
11.	V-B (32)	V-A (72)	V-A (43)
12.	II-A (35)	II-B (74)	II-A (44)
13.	II-B (42)	III-C (81)	VI-B (51)
14.	V-A (48)	III-B (82)	II-B (56)
15.	V-C (54)	V-C (83)	III-C (59)
16.	III-C (59)	VI-A (83)	V-C (66)
17.	III-B (65)	VI-B (86)	III-B (77)

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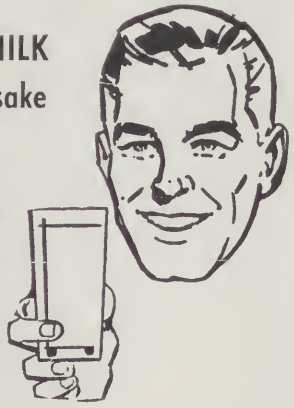
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Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.

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LETTER TO THE EDITOR

Dear Editor:

In the June 1968 issue of the MARYLAND STATE MEDICAL JOURNAL Doctor Arthur G. Siwinski, President of the Medical and Chirurgical Faculty, in an editorial raised the question, "Is the medical school philosophy responsible for health manpower shortage?"

Doctor Siwinski quoted from the 1967-68 Study on Health Manpower Needs for Maryland conducted under the auspices of the Advisory Council on Higher Education, "If current trends continue, there will be a moderate shortage of physicians in Maryland by 1980." Doctor Siwinski disagreed with this conclusion and stated the "shortage will be acute".

The Advisory Council on Higher Education study of Maryland's physician needs conducted during 1967-68 took into consideration:

1. The growth in the National and Maryland population.
2. The expansions planned for both the Johns Hopkins Medical School and the University of Maryland Medical School.
3. The increase in number and size of new and existing medical schools in the United States.
4. Increased demand for services of physicians by our society.

Considering all these factors the study concluded that the shortage of physicians in Maryland in 1980 will be only a moderate one. There is no factual basis for concluding that there will

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be an acute shortage of physicians by 1980 if current trends continue. There may be a maldistribution of physicians.

Dr. Siwinski further attributes the possibility of a shortage of physicians to current trends in medical school to emphasize the research approach to medical problems. The research approach to patient care means carefully evaluating patient care results from therapy given and not accepting diagnosis and therapy impressions that are not backed up by significant evidence of their value. Clinical research is fundamentally keeping careful records of patient diagnosis and therapy with a follow up to determine ultimate results. These types of experiences must be accumulated in sufficient numbers to bring the observations into significant levels before conclusions can be drawn.

Practically all of the progress in patient diagnosis and care that has taken place in this century has been the results of such studies. Clinical practice without these types of discriminating studies has not advanced medical care or preventive medicine in this or any other time.

Medical schools foster inquiry and critical evaluation of disease, injury, and patient care. Present standards of medical practice have this as their solid foundation. Only about five percent of U. S. physicians are involved in full-time medical teaching and research. Research is not depleting the ranks of the medical practitioner but making him more discriminating and reliable in delivering excellent patient care. There is a real effort on the part of medical graduates to not repeat the mistakes in patient care of yesterday but to give the patient the best possible opportunity and support for good health and longevity.

William S. Stone, MD
Dean
University of Maryland School of Medicine

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Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
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Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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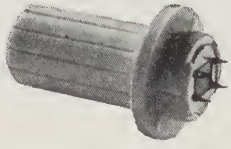
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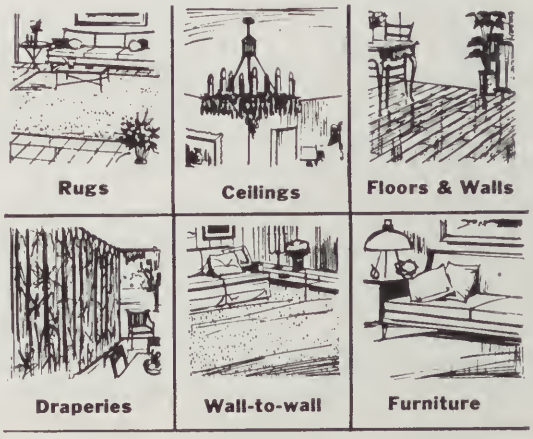
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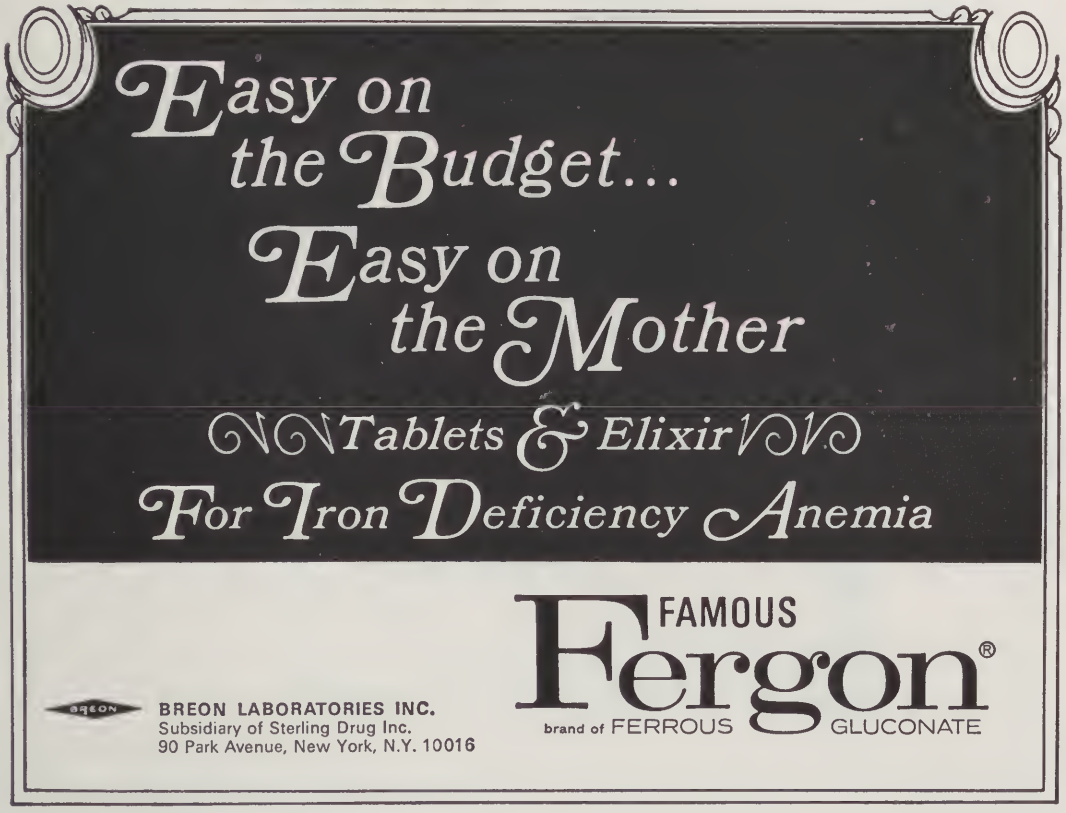
ETHICS CORNER

One of the most common queries or complaints received by the Faculty office deals with the submission of Consultation, Evaluation or other types of medical reports to attorneys for patients whose medical problem involves legal action.

While the Medicolegal Code of Cooperation clearly spells out the responsibilities of the physician and the attorney, it is silent with respect to the responsibility for payment for such reports.

In discussing this problem within the Joint Medicolegal Committee of the Bar Associations and the Faculty, it has been learned that the attorney may advance sums for the development of contemplated legal action, provided he has reasonable assurance of repayment of such sums.

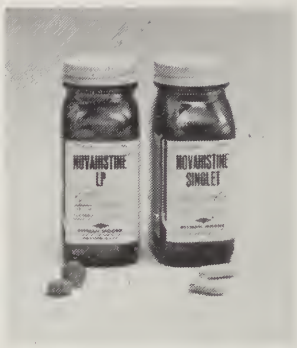
The Joint Committee has under consideration an amendment to the Code of Cooperation that would clarify this. In the meantime, it is not considered unethical for the physician to request advance payment for his reports to the attorney. It is also not considered unethical for the physician to ask for clarification as to who will pay for such services.



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The American Academy of Clinical Toxicology

The recently founded American Academy of Clinical Toxicology will hold an organizational meeting in Chicago on October 22. The new Academy has been established for the purpose of advancement of clinical toxicology, a specialty concerned with the diagnosis and treatment of poisoning and drug intoxication.

The purposes of the Academy are to encourage clinical investigation; to promote the development of diagnostic and therapeutic methods; to foster among practicing physicians a better understanding of the treatment of poisoning; and to improve the medical care received by the poisoned patient.

Five categories of membership are provided: Fellowship—physicians in the full-time practice of clinical toxicology with five-years' experience and who have been judged by the Examining Committee to have fulfilled the requirements set forth by the Constitution and By-laws; Active—physicians who are called upon to provide clinical care for the poisoned patient as part of their practice; Associate—physicians with no direct involvement in patient care, and scientists whose activities contribute to the advancement of clinical toxicology; Honorary—non-members elected to membership in recognition of distinguished service or contributions to the objectives of the Academy; Sustaining—provided for organizations wishing to contribute additional financial support to the Academy as an aid in the achievement of its objectives.

The Academy will provide its members with a suitable periodical for the publication of original contributions to clinical toxicology. In addition to an annual business meeting and scientific program, the Academy will sponsor a symposium on some aspect of the practice of clinical toxicology with the proceedings to be distributed to the membership. Ad Hoc committees will be appointed by the Academy to prepare special reports intended to assist the physician toward better utilization of available resources. Subjects under consideration are: Emergency room facilities; ER and ICU nursing; Rapid analytical procedures; Documentation and reporting of toxic reactions.

Clinical Guidelines in the treatment of poisoning will be a series of brief discussions limited to individual toxic substances presenting pertinent data required for clinical management. The Academy will maintain a register of consulting clinical toxicologists by geographic area to whom physicians calling for assistance may be referred.

An active program of continuing education will be pursued by the Academy to provide the physician in practice with opportunity for specialized training in the management of poisoning. The Academy will sponsor annually a two-to three-day intensive training program on the treatment of poisoning. The Academy will participate with regional and local medical groups in the presentation of one-day training programs by provision of teaching aids and assistance in the location of suitable faculty.

Applications for Charter Membership and further information may be obtained from: Eric G. Comstock, MD, Acting Secretary-Treasurer, American Academy of Clinical Toxicology, PO Box 2565, Houston, Texas 77001.

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Partnership for Health Extended To Mid-1970

The Partnership for Health legislation, which President Johnson described as an attempt to cure "red tape" in federal health programs, was signed into law late in 1967. It is now public law 90–174. The measure extends the year-old comprehensive health planning program to June 30, 1970; it authorizes $589 million in federal funds for grants to states and project grants for planning and related services, including training, research and demonstration; and it sets regulations for licensing of clinical laboratories operating in interstate commerce.

At the White House signing ceremony, President Johnson pointed out that the federal government has kept apace with advances in medical science by introducing "dozens and dozens" of new health bills during the last four years. Each new program, the President stated, is "valid and valuable for its own purpose," but the large number of new programs has caused "a programmatic and bureaucratic nightmare."

The President stated that the purpose of the legislation "is not to create a new program, but to try to consolidate some old ones." The Partnership for Health law, he stated, "gives our states and it gives our communities new power to mount a total war against sickness and against disease—and they need power." He pointed out that the legislation "offers assistance to states and communities to develop broadbased plans for health."

The $589 million appropriation was allotted in eight categories as follows:

1. Research and demonstrations related to delivery of health services.
2. Grants to schools of public health.
3. Statewide planning.
4. Areawide planning.
5. Training, studies, and demonstrations in planning.
6. Health service formula grants.
7. Health service project grants.
8. Experimental facilities.

Continuing Education for Medical Assistants

In this age of new concepts, techniques and devices, members of the medical team realize the need for continuing education.

"Rx for All Busy Physicians" describes the American Association of Medical Assistants' continuing education program for physicians' office assistants—Certification.

Established in 1961, the AAMA Certifying Board administers an annual examination covering the administrative and clinical responsibilities of medical assistants. The eight-hour examination is given in June at locations throughout the United States.

Certification may be attained in the clinical and/or administrative categories. The examination covers the following sections: ☐ Medical terminology, anatomy and physiology ☐ Personal adjustment and human relations; oral communications, medical ethics and etiquette ☐ Medical law and economics ☐ Office skills; secretarial and administrative procedures; written communications ☐ Accounting, credits and collections; records, medical and non-medical ☐ Examination room techniques; sterilization procedures; care of equipment ☐ Laboratory orientation.

For additional information about the Certification program for medical assistants contact AAMA, 200 East Ohio Street, Chicago, Illinois 60611.

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PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles.

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Fees Should Keep Pace With Inflation

America's doctors overwhelmingly agree with the appeal of a former president of the American Medical Association that raises in fees should strictly keep pace with inflation.

The former AMA president, James Z. Appel, MD, a Lancaster, Pa. general practitioner, said earlier this year that for doctors "to make a fortune out of people's illnesses is not quite ethical." He asked his fellow physicians to "hold down the acceleration of our professional incomes" and to increase fees only "enough to keep pace with inflation." Dr. Appel also called on doctors to help cut down their patients' hospital bills.

Of the 1,200 physicians who answered a monthly national poll (called Playback) conducted in April by Marion Laboratories, Inc., headquartered here, a whopping 75% agreed with Dr. Appel's appeal to hold fees down only to inflation increases. (20% disagreed and 6% were undecided.)





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Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
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Late News Notices

BALTIMORE CITY MEDICAL SOCIETY MEETING

FRIDAY, OCTOBER 4, 1968—8:30 P.M.

"Health Manpower's New Breed: Are You Sleeping Through a Revolution?" Richard J. Davidson, Director of Education, Maryland—D.C.—Delaware Hospital Association.

MARYLAND SOCIETY OF INTERNAL MEDICINE/SECTION OF INTERNAL MEDICINE OF BALTIMORE CITY MEDICAL SOCIETY

Fall Joint Meeting: October 7, 1968—8:15 P.M., Osler Hall, 1211 Cathedral St., Baltimore. Speaker: George A. Silver, MD, Deputy Assistant Secretary for Health and Scientific Affairs, Department of Health, Education and Welfare. Topic Aims and Accomplishments of Federal Health Policy.

MARYLAND KIDNEY FOUNDATION

Seminar on Prostaglandins—Evidence of their Role in Hypertension: October 16, 1968—5:00 P. M., University of Maryland Hospital Psychiatric Institute, Room 1-704. Speaker: James B. Lee, MD, Associate Professor of Medicine, St. Louis University School of Medicine.

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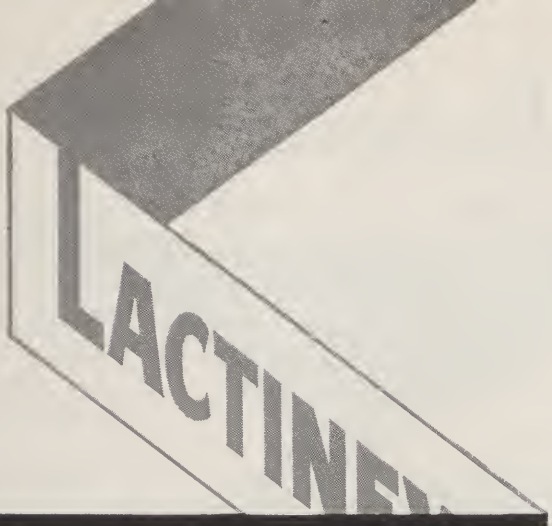


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ON THE COVER—This month, **Aaron Sopher** again has appeared on the scene—this time with his 1968 pictorial review of the Haight-Ashbury situation to tie in with our issue on drug abuse. While **Mr. Sopher's** renditions were being inked with his satirical pen, gun battles were going on in Golden Gate Park, the **Berkeley Barb** was still being published once a week (as far as we know, it still is), and Maryland's teenagers were being arrested for staging their own happenings with the aid of marihuana and LSD.

EDITORIAL and BUSINESS OFFICE: 1211 Cathedral Street, Baltimore, Maryland 21201. 539-0872 (Area Code 301).

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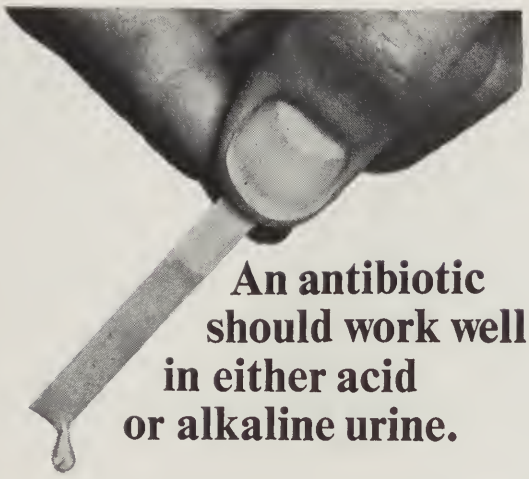
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Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system – anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin – maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney – rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth – dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

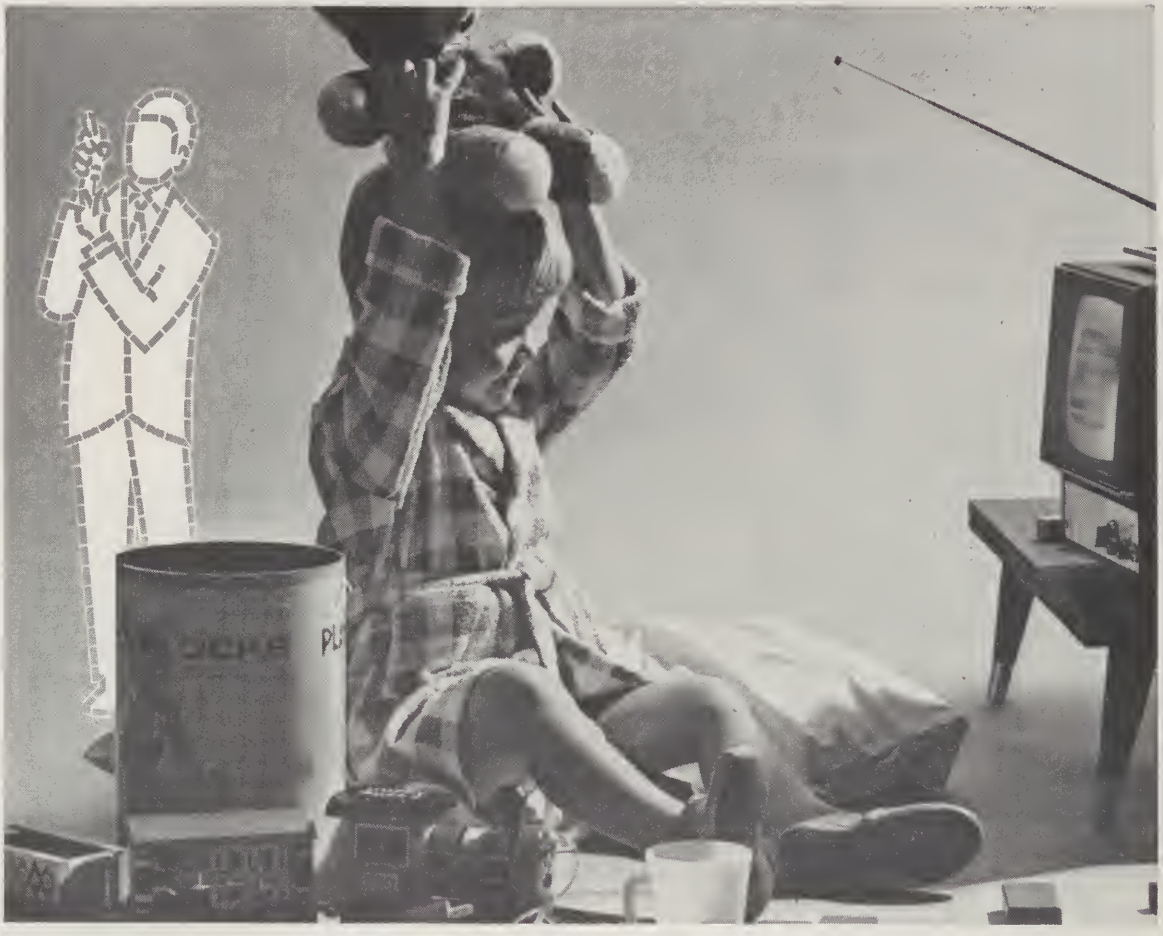
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Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K® (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567A] 800197

Additional information available to physicians upon request.

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Doctors take note...

OCTOBER 21-25, 1968
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Current Concepts of Neurology: Diagnosis and Treatment: University of Maryland School of Medicine, Baltimore, Md. Director: Erland Nelson, MD. Contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

OCTOBER 27, 1968
PENNSYLVANIA MEDICAL SOCIETY

Symposium—Group Practice: Evening program open to all physicians including interns, residents, and students without fee: Pennsylvania Medical Society, Chatham Center, Pittsburgh. Contact: Committee on Convention Program, Pennsylvania Medical Society, Taylor Bypass & Erford Road, Lemoyne, Pa. 17043.

OCTOBER 27-28, 1968
PENNSYLVANIA MEDICAL SOCIETY

Seminar—Electrolyte Metabolism and Renal Diseases: Water and Sodium in Health and Illness, Potassium Outside and Inside Cells, Renal Disorders: Nephritis and Nephrosis, Management of Urinary Infections and of Uremia: Pennsylvania Medical Society, Chatham Center, Pittsburgh. Contact: Committee on Convention Program, Pennsylvania Medical Society, Taylor Bypass & Erford Road, Lemoyne, Pa. 17043.

OCTOBER 27-28, 1968
AMERICAN SOCIAL HEALTH ASSOCIATION

Conference—National Leadership: Venereal Disease Research Priorities: Biologic, Behavioral and Control: Biltmore Hotel, New York. Contact: American Social Health Association, 1740 Broadway, New York, N.Y. 10019.

OCTOBER 28, 1968
PENNSYLVANIA MEDICAL SOCIETY

Seminar—Renal Diseases: Open to nurses and allied professions: Pennsylvania Medical Society, Chatham Center, Pittsburgh. Contact: Committee on Convention Program, Pennsylvania Medical Society, Taylor Bypass & Erford Road, Lemoyne, Pa. 17043.

OCTOBER 28, 1968
PENNSYLVANIA MEDICAL SOCIETY

Symposium—Status of Organ Transplantation: Evening program open to all physicians, nurses, allied professions and the public without fee: Pennsylvania Medical Society, Chatham Center, Pittsburgh. Contact: Committee on Convention Program, Pennsylvania Medical Society, Taylor Bypass & Erford Road, Lemoyne, Pa. 17043.

OCTOBER 28-NOVEMBER 1, 1968
DEPARTMENT OF OBSTETRICS AND GYNECOLOGY OF THE COLLEGE OF PHYSICIANS AND SURGEONS, COLUMBIA UNIVERSITY, NEW YORK

Course—Obstetrical and Gynecological Pathology: Columbia University. Contact: Equinn W. Munnell, MD, FACOG, College of Physicians and Surgeons of Columbia University, 630 West 168th Street, New York, N.Y. 10032.

OCTOBER 28-NOVEMBER 1, 1968
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Rheumatic Diseases: Pathology, Immunology, Diagnosis and Treatment: Peter B. Brigham Hospital, Boston, Mass. Director: Theodore B. Bayless, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

OCTOBER 29, 1968
MARYLAND SOCIETY FOR THE RHEUMATIC DISEASES

Symposium—Management and Diagnosis of Rheumatoid Arthritis: 8 P.M., Osler Hall, 1211 Cathedral St., Baltimore. Moderator: Harry F. Klinefelter, MD. Panelists: Charles W. Wainwright, MD, Alexander S. Townes, MD, Werner Barth, MD, Paul Richardson, MD, George N. Austin, MD. Contact: Richard G. Ballard, MD, Society for the Rheumatic Diseases, 12 West 25th St., Baltimore, Md. 21218.

OCTOBER 29, 1968
PENNSYLVANIA MEDICAL SOCIETY

Scientific Sessions—Pa. Allergy Association, Pa. Chapter American College of Chest Physicians, Pittsburgh Academy of Dermatology, Pa. Society of Internal Medicine, Mid-Atlantic Neurosurgical Society, Pa. Acad. of Ophthalmology & Otolaryngology, Pa. Orthopaedic Society, Pa. Acad. of Physical Medicine & Rehabilitation, Pittsburgh Proctologic Society, Pa. Psychiatric Society: Pennsylvania Medical Society, Chatham Center, Pittsburgh. Contact: Committee on Convention Program, Pennsylvania Medical Society, Taylor Bypass & Erford Road, Lemoyne, Pa. 17043.

OCTOBER 31, NOVEMBER 1-2, 1968
AMERICAN COLLEGE OF GASTROENTEROLOGY

Annual Postgraduate Course—Advances in Diagnosis and Treatment of Gastrointestinal Diseases and Comprehensive Discussion of Diseases of the Esophagus, Stomach, Pancreas, Liver and Gallbladder, Colon and Rectum: Statler Hilton Hotel, Boston, Mass. Contact: American College of Gastroenterology, 33 West 60th Street, New York, N.Y. 10023.

NOVEMBER 6-9, 1968
AMERICAN SOCIETY OF CYTOLOGY/CLEVELAND SOCIETY OF OBSTETRICIANS AND GYNECOLOGISTS

Annual Scientific Meeting—Sheraton-Cleveland Hotel, Cleveland, Ohio. Contact: Warren R. Lang, MD, FACOG, Secretary-Treasurer, American Society of Cytology, 7112 Lincoln Drive, Philadelphia, Pa. 19119.

NOVEMBER 6-17, 1968
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Seminar Cruise—Lectures, panels and discussions on wide variety of subjects aboard luxury cruise ship the Victoria. Contact: Allen Travel Service, Inc., 565 Fifth Avenue, New York, New York 10017.

NOVEMBER 7, 1968
INSTITUTE OF RECONSTRUCTIVE PLASTIC SURGERY

Seventh Annual V. H. Kazanjian Lecture—Skin: New York University Medical Center, 550 First Avenue, New York, N.Y., 5 P.M. Contact: Philip Merwin, New York University Medical Center, 550 First Avenue, New York, N.Y. 10016.

NOVEMBER 7-9, 1968
THE MOUND PARK HOSPITAL FOUNDATION/THE J. HILLIS MILLER HEALTH CENTER UNIVERSITY OF FLORIDA

Second Annual Conference—Today's Hospital Problems: An Interdisciplinary Approach: Tides Hotel and Bath Club, Redington Beach, Florida. Leadership course for Chiefs of Staff, Hospital Administrators and Governing Personnel (or Trustees). Contact: Postgraduate Medical Education, Mound Park Hospital Foundation, Inc., St. Petersburg, Fla. 33701.

NOVEMBER 11-15, 1968
NEW YORK UNIVERSITY MEDICAL CENTER/THE AMERICAN ASSOCIATION OF INDUSTRIAL NURSES

Course—Occupational health: New York University Medical Center. Director: David H. Goldstein, MD. Coordinator for nurse faculty: Sara P. Wagner, RN. Limited to nurses with five or less years experience in occupational health. Contact: Office of the Recorder, New York University Post-Graduate Medical School, 550 First Avenue, New York, N.Y. 10016.

NOVEMBER 13, 1968
MEDICAL AND CHIRURGICAL FACULTY/MARYLAND CHAPTER, ACADEMY OF GENERAL PRACTICE/MARYLAND CHAPTER, ACADEMY OF PEDIATRICS/MARYLAND PSYCHIATRIC SOCIETY/MARYLAND SOCIETY OF INTERNAL MEDICINE

Symposium—Twentieth Century Adolescent: The Eastwind, Baltimore, Md. Open to all physicians, their wives, and professionally allied colleagues. Contact: Office, Medical and Chirurgical Faculty, 1211 Cathedral St., Baltimore, Md. 21201. (*See page 25 for more program details.*)

NOVEMBER 14, 1968
NEW YORK STATE ACTION FOR CLEAN AIR COMMITTEE/SISTERS OF CHARITY HOSPITAL/SCHOOL OF MEDICINE OF THE STATE UNIVERSITY OF NEW YORK/CANADIAN THORACIC SOCIETY/ONTARIO THORACIC SOCIETY/TUBERCULOSIS AND RESPIRATORY DISEASE COMMITTEE OF NIAGARA COUNTY

Symposium—Air Pollution and the Respiratory Patient: An International Problem: Kinch Auditorium of Sisters of Charity Hospital, Buffalo, New York. Director: LaVerne E. Campbell, MD. Contact: New York City office of the New York State Action for Clean Air Committee, 105 East 22nd Street, New York, N.Y. 10010.

NOVEMBER 18-20, 1968
HAHNEMANN MEDICAL COLLEGE AND HOSPITAL

Postgraduate Course—Psychiatry in Internal Medicine: Sheraton Hotel, Philadelphia, Pa. Directors: Paul Jay Fink, MD, Wilbur W. Oaks, MD. Contact: Hahnemann Medical College and Hospital, 230 North Broad Street, Philadelphia, Pa. 19104.



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executive secretary's newsletter

October, 1968

REGIONAL CONFERENCE ON HEALTH CARE COSTS

The U. S. Department of Health, Education and Welfare is planning a Regional Conference on Health Care Costs for December 10 and 11 in Harrisburg, Pa.

Those interested in attending may call the Faculty office for further details. The region involved includes the following states, as well as Maryland: Kentucky, West Virginia, Pennsylvania, Virginia Virgin Islands, Puerto Rico and the District of Columbia.

SEPARATE NARCOTIC LICENSES

U. S. Treasury Department requirements under the law require that physicians have separate narcotic licenses for each office location where they issue prescriptions for narcotics. Violations of this rule can result in a federal government fine.

NEW ISSUE OF LAWS, RULES AND REGULATIONS

The booklet, Laws, Rules and Regulations with which Physicians Must Comply has been revised through July, 1968. Copies of the revised publication may be obtained through the Faculty office.

RX BLANK REFILL CODE

Physicians are again reminded of a recent agreement with the Maryland Pharmaceutical Association that the current "refill code" appearing at the lower left-hand corner of some prescription blanks should be eliminated as soon as current stocks of such blanks are exhausted.

If refills are approved for such prescriptions, the indication should be made at the bottom of the blank in the physician's own handwriting.

Copies of the Code of Cooperation between physicians and pharmacists are available through the Faculty office.

AMA JUDICIAL COUNCIL OPINION RELATING TO DOCTORS OF OPTOMETRY

The Judicial Council of the AMA has adopted a ruling dealing with the relationship of a doctor of medicine and a doctor of optometry. The opinion was issued on June 15, 1968.

In a question posed to the Council, it was asked if it is ethical for a doctor of medicine to refer his patient to a qualified optometrist solely for optometric care. In the reply it was stated:

"In the opinion of the Judicial Council a doctor of medicine may send his patient to a qualified and ethical optometrist solely for optometric service. The physician would be ethically remiss, of course, if before doing so he did not insure that there was an absence of any medical reason for his patient's complaint, and he would be equally remiss if he sent a patient without having made a medical evaluation of the patient's condition."

BLUE SHIELD CLAIM FORMS

Maryland's Blue Shield forms contain an area for insertion of the physician's Usual, Customary and Reasonable charge. In completing this, physicians are reminded that this should not be the Blue Shield allowance for the procedure involved, but the Usual, Customary and Reasonable charge ordinarily made by the physician regardless of the patient's income, or Blue Shield benefits.

AMERICAN MEDICAL ASSOCIATION CHANGES

Frank J. L. "Bing" Blasingame, MD, has terminated his services as Executive Vice President of the AMA. The joint announcement was made by the AMA Board of Trustees and Dr. Blasingame.

Shortly after this announcement was made, Acting Executive Vice President Ernest B. Howard, MD, announced approval by the Board of formation of a new Division of Public Affairs within the AMA. It consolidates the former AMA Field Division and the former Field Service of the AMPAC organization.

DISPOSABLE HYPODERMIC NEEDLES

Complaints are being received in the Faculty office that some children are obtaining disposable hypodermic syringes from the trash receptacles which physicians have placed out for collection.

Physicians are urged to effectively destroy such syringes before placing them in the refuse so they may cause no harm through being an "attractive nuisance."

DRUG SAMPLES

Physicians are also advised to dispose of surplus drug samples by flushing them down the drain; or arranging for their pickup through the Woman's Auxiliary representative in their area. The Auxiliary has a project where surplus drugs are collected for eventual shipment to South Viet Nam and other areas throughout the world.

John Sargent

Executive Secretary

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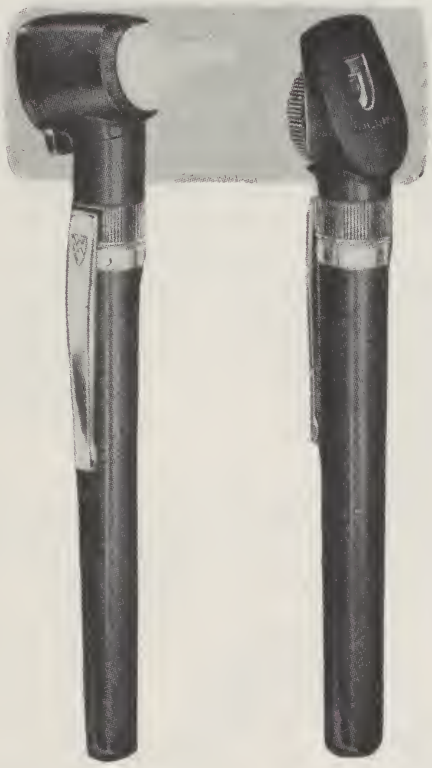
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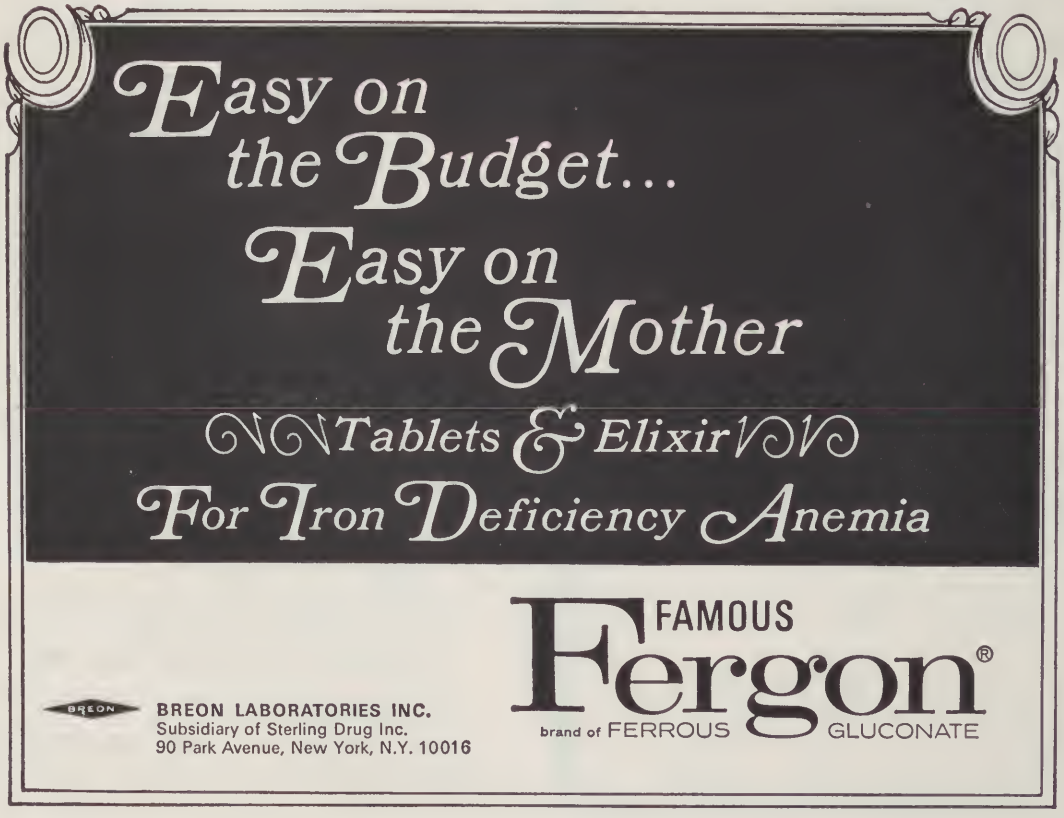
AMA and Medical Economics Surveys

The news media gave much attention recently to a survey conducted by the magazine *Medical Economics* which indicated a median income level of $32,170 for United States physicians during 1966. This represented an 11% increase from the previous year. The figure was based on a survey of 2028 doctors under the age of 65 selected at random from the membership of the AMA. Annual median net income for board certified OB-GYN specialists is $36,000 according to a similar survey.

A recent survey conducted by the American Medical Association on how physicians spend their working hours included a breakdown by specialty which also reveals some interesting facts.

First, the survey revealed that most physicians practice 48 weeks a year. About 11% practice the total 52 weeks of the year. Office oriented physicians practice an average of 56 hours a week. However, obstetrician–gynecologists practice 59 hours a week which is the top figure for specialties reported upon. This compares with the low weekly figure of 48 hours a week practiced by psychiatrists. Pediatricians are in the middle, practicing 56½ hours per week.

Of the 56 hours practiced by most physicians, more than 45 were for direct care of patients; six hours were devoted to office administration, insurance claim forms, continuing education, and medical society or hospital staff meetings; two hours were devoted to scientific research and/or teaching; three hours were for salaried practice.





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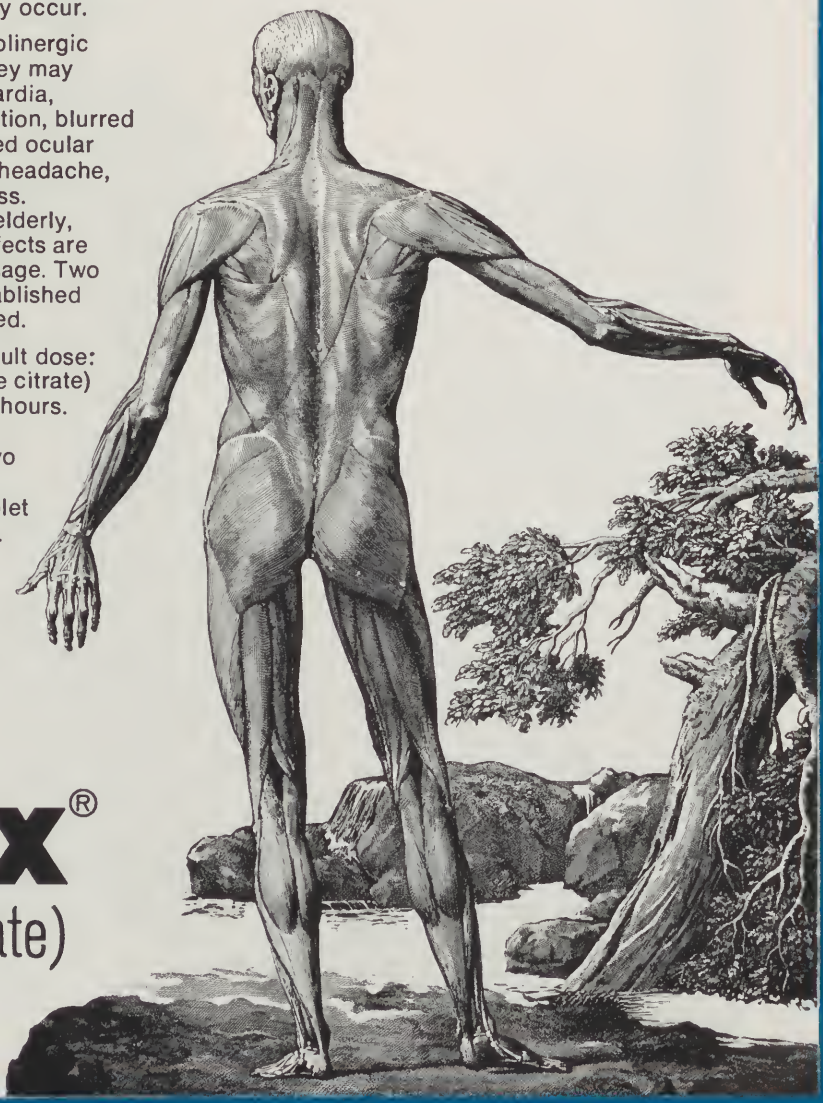
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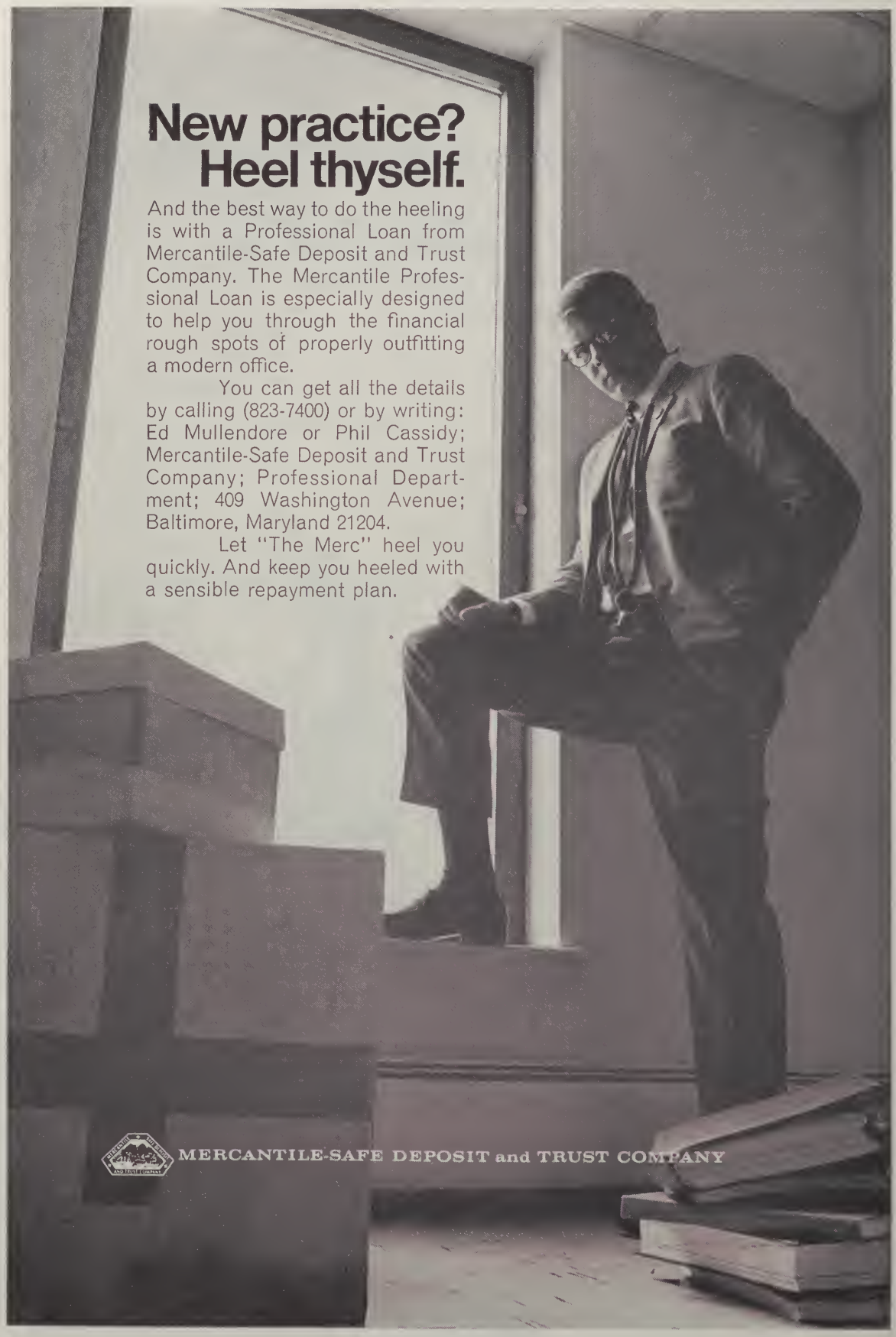
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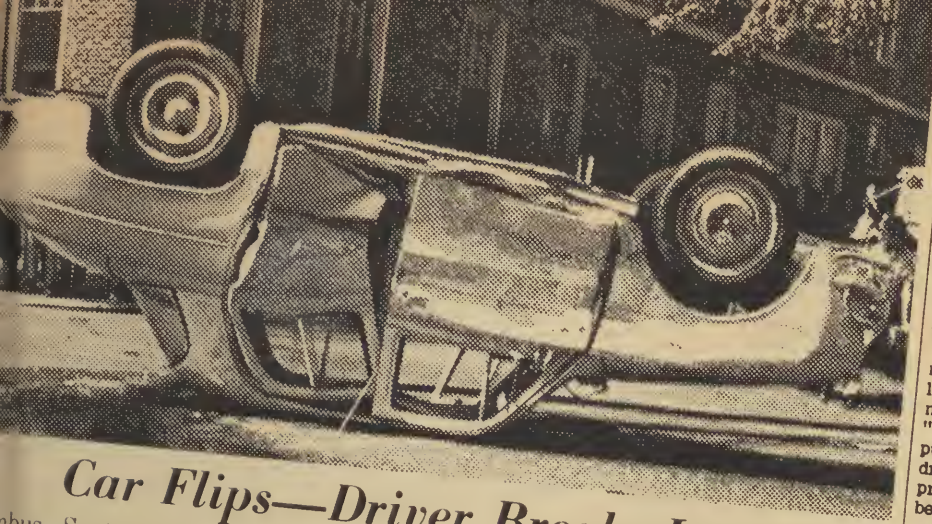
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Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150	mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5	mcg.
Iron, Elemental (as Ferrous Fumarate)	110	mg.
Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropriat investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequat vitamin B_{12} therapy may result in hematologic remission but neu rological progression. Adequate doses of vitamin B_{12} (parentera or oral with potent intrinsic factor as in Trinsicon® [hematini concentrate with intrinsic factor, Lilly]) usually prevent, halt, c improve the neurological changes.

As with all preparations containing intrinsic factor, resistanc may develop in some cases of pernicious anemia to the potentia tion of absorption of physiological doses of vitamin B_{12}. If resis ance occurs, parenteral therapy, or oral therapy with so-calle massive doses of vitamin B_{12}, may be necessary. No single reg men fits all cases, and the status of the patient observed i follow-up is the final criterion for adequacy of therapy. Periodi



You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

Iron (110 mg.)—treats hypochromic anemia.

clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500. [032568]

Additional information available to physicians upon request.
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The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart

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THE 20th CENTURY ADOLESCENT

WEDNESDAY, NOVEMBER 13, 1968

A symposium for all physicians, their wives, professionally allied colleagues, and members of the legal profession who are concerned with the newer psychologies of adolescent behavior.

Time: Symposium—1:15 to 5:00 P.M.
Reception—5:00 P.M.
Banquet—6:00 P.M.

Place: The Eastwind
9000 Pulaski Highway
Baltimore, Maryland

Sponsors: Medical and Chirurgical Faculty of Maryland/Maryland Chapter, American Academy of General Practice/Maryland Chapter, American Academy of Pediatrics/Maryland Psychiatric Society/Maryland Society of Internal Medicine

Supported through a grant-in-aid from Geigy Pharmaceuticals, Ardsley, New York

PROGRAM

1:15 P.M.—*Symposium Welcome.*
John Whitridge, Jr., MD
Chairman, Committee on Postgraduate Education, Preventive Medicine, and Public Health, Medical and Chirurgical Faculty

1:20 P.M.—*The Adolescent Patient: An Overview.* **Sheldon D. Glass, MD**
Co-Director Family and Youth Center; and Co-Psychiatrist in Charge of Adolescent Psychiatry Center, The Johns Hopkins University School of Medicine, Baltimore

1:40 P.M.—*Implications of the Sex Revolution for the Adolescent's Search for Sexual Identity.*
James F. Masterson, Jr., MD
Associate Professor of Clinical Psychiatry, Cornell University Medical Center; and Attending Psychiatrist, Payne Whitney Clinic, New York

2:15 P.M.—*Drug Addiction, Psychedelic Hoaxes and Modern Youth.* **Dale G. Friend, MD**
Assistant Professor of Medicine, Harvard Medical School, Boston

2:50 P.M.—Recess

3:05 P.M.—*Depression in Adolescents and College Students.* **Francis J. Braceland, MD**
Editor, *American Journal of Psychiatry;* and Senior Consultant, Institute of Living, Hartford

3:40 P.M.—*Legal Obligations in Dealing with the Rebellious, Odd-Ball Adolescent.*
William J. Curran, LLM, SMHyg
Professor of Health Law, Harvard Medical School, Boston

4:15 P.M.—*Panel Sessions: Questions and Answers*
Moderator: Dr. Glass
Panelists: Drs. Braceland, Curran, Friend, and Masterson

5:00 P.M.—Cocktail Reception
For physicians, their wives and guests

6:00 P.M.—*The Changing Status of Adolescents in the Modern World.* **Margaret Mead, PhD**
Curator of Ethnology, The American Museum of Natural History; and Adjunct Professor of Anthropology, Columbia University, New York

Admission tickets for symposium lectures are free, but because of the current widespread interest in the subject, all applications for admission tickets will be handled strictly in order of receipt. There is a nominal charge of five dollars ($5) per person for the cocktail reception and banquet. Mail reservations by November 7 to:

John Whitridge, Jr., MD
P. O. Box 9791
Baltimore, Maryland 21204

For further information call the Medical and Chirurgical Faculty office:

(301)539-0872

A complete program will be mailed to all physicians in Maryland and other individuals may receive a copy by calling the Faculty office.



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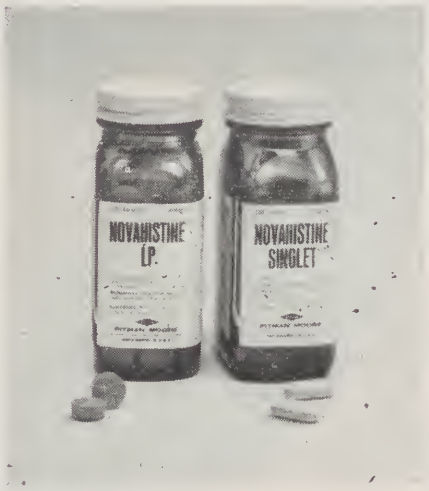
Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

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MRS. HARRY L. BERMAN, EDITOR

Highlights of the San Francisco Convention

Conducted tours through a unique rehabilitation mobile unit, closed-circuit TV programs and an afternoon of continuous health education films were outstanding features of the 45th Annual Convention of the Woman's Auxiliary to the American Medical Association held at San Francisco's St. Francis Hotel, June 16-19.

Highlighting the four-day session was the mobile demonstration unit called "Homemaking Unlimited." A five-ton coach, sponsored by the University of Nebraska School of Home Economics, showed handicapped housewives how to be self-reliant homemakers despite physical limitations. The unit contained specially designed homemaking features such as kitchens, baths and storage space.

Widespread attention was given to the AMA closed-circuit TV shows with Auxiliary members as guests depicting their supporting roles to physicians and community service activities. One five-minute show was aired each morning, Monday through Wednesday. Subjects included "Why an Auxiliary," "The Doctor's Wife Rose," and "Accent on Youth." A 15-minute Auxiliary show was broadcast at prime time—6 P.M., Monday through Wednesday. Topics covered were "Homemaking Unlimited," "Home-Centered Health Care," and "Auxiliary Community Service Projects."

Philip Lesly, President of the Philip Lesly Co., a public relations firm, and counsel to the AMA, formally opened the convention with a speech urging Auxiliary members to become a vital part of the health-care system. (See September JOURNAL for text of Mr. Lesly's speech.)

Milford O. Rouse, MD, 1967-68 AMA President, spoke on "The Physician's Finest Hour" during the Monday luncheon honoring Auxiliary past presidents and AMA officers, trustees and their wives.

The Auxiliary's annual contribution to the AMA Education and Research Foundation amounted to $389,824.64. Eight state auxiliaries received awards of merit at the Monday luncheon for having the largest percent of increase per capita in each of four regions.

The Tuesday afternoon communications program featured Mrs. C. Rodney Stoltz, communications committee chairman; Mrs. John Wagner, editor, *MD's Wife;* and Mrs. Paul Sauvagoot, contributing editor, *MD's Wife.* They discussed helpful suggestions for communicating as individuals and as a group. Following the program, films emphasizing the role of motion pictures and health education in Auxiliary progress, were shown.

Mrs. C. C. Long, new president, opened the Wednesday session with an inaugural address suggesting that auxiliary programs focus on "Accent on Youth." She encouraged auxiliaries to use widely available material to implement programs that are needed in their communities and said, "we are obligated to help our boys and girls through all the educational means that we have at our disposal."

Other officers installed were: Mrs. John M. Chenault, Decatur, Ala., president-elect; Mrs. G. Prentiss Lee, Portland, Ore., first vice-president; and the regional vice-presidents.

Additional convention features were: an evening reception honoring the out-going president, Mrs. Ritter, and the new president, Mrs. Long; a luncheon honoring the leaders of women's volunteer organizations; reports from state auxiliary presidents; addresses by other chairmen and officials; and finally a roundup report on AMA's House of Delegates activities by E. B. Howard, MD, AMA assistant executive vice-president.



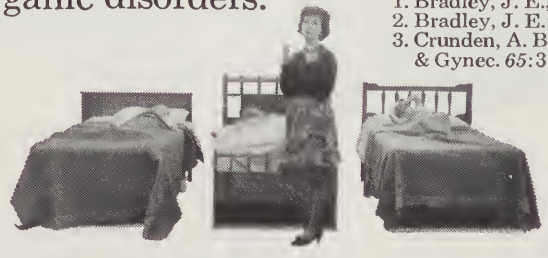
Delegates to the national convention in San Francisco last June included (front row, left to right) Mrs. John Hirschfeld as an alternate; Mrs. Leonard Warres, President of the Auxiliary to the Medical and Chirurgical Faculty; Mrs. Wallace Sadowsky, President-Elect; (back row) Mrs. William Stone, Immediate Past President; and Mrs. McKendree Boyer, Delegate. (Not pictured is Mrs. John Ball, another Delegate.)



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1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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Your library is in the Faculty headquarters, second floor front. From its offices, reading rooms and stacks, it sends books to physicians, to hospital or university libraries, and even to libraries of allied sciences in colleges and schools in Maryland. Acting as an agent, it borrows books from other libraries, if necessary, for your reference use. Consider these other locations as branch offices serving learned communities in every county of Maryland.

At each Faculty convention, and at some seminars, you will find a display of recent library acquisitions for your examination, and a librarian to help you select books in your field of interest.

With services so broad in scope, with ample facilities, and librarians generous in their offers of assistance, why are the reading rooms not filled? As long as Faculty dues support its library, here are some practical suggestions to make it worth more to members.

First, scan the accession list published in this JOURNAL. Read book reviews occasionally, and look for books on the list which have good reviews, or for others which have appeal. Then ask the library to send one or more books to your office or to your hospital library on loan.

Second, check references cited in technical articles or editorials, in some professional news items, or even on drug package inserts. Additional information that could not be included in the text, and which better covers other aspects of the subject, may often be found. Such pursuit of references turns up interesting data, may lead you to valuable historical sources, and is always good mental exercise.

Third, request a bibliography on a subject of special interest. Lists like these have particular value when the field is new or unusual, or when they furnish information which is not available in texts. Carefully defined problems or clearly described professional areas generate the best bibliographies. The librarian may occasionally require some consultation with the physician in order to assemble a good reading list.

Fourth, should you wish to purchase books in a new field of interest for your own library, discuss your plans with the librarian. She can suggest volumes of significant historical worth, or help select current important publications. Less costly paperback editions include valuable reprints as well as modern texts; these may fill all your needs for special topics in a personal library.

Fifth, suggest books in areas of special interest for the library to purchase, and furnish a brief description and critique of each.

Sixth, consult the librarian before donating books or journals. Some texts have special value, others replace lost or worn-out volumes, and many can be transferred to other libraries. Unusual journals, complete sets and texts less than ten years old are most desirable.

Seventh, use the library to help you write for others to read. Borrow books on the techniques of medical writing, if you own none. Write for your patients. They need instructions, explanations and advice about matters of common occurrence. Write case reports for journals. Write letters to editors. Write the library for a free bibliography on physical fitness. Writing helps you to read better.

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JOHN B. DeHOFF, MD, MPH
Baltimore City Health Department

Cleaning House

Books being discarded from the Medical and Chirurgical Faculty Library are being held on shelves in the basement of the Faculty Building until November 1, 1968 in order that any interested member of the Faculty might select any books of interest for his own book collection.

New Accessions

BOOKS

(Arranged by author and title)

RE 3 A5 1967 — **Ameriean Publie Health Assoeiation Program. Area Committee on Child Health.** Services for children with eye problems. New York, American Public Health Association, Inc., 1967.

Z 6658 B3 1968 — **Baylor University Medieal Center.** Catalogue of The Ruth & Lyle Sellers Medical Collection. Dallas, Texas, Baylor University. 1968.

RD 32 B4 1968 — **Beattie, Edward J.** An atlas of advanced surgical techniques. Philadelphia, Pennsylvania, W. B. Saunders Company, 1968.

Ref. Z 6658 B5 1967 — **Blake, John Ballard** Medical reference works, 1679-1966; a selected bibliography. Chicago, Medical Library Association, 1967.

RC 904 B7 1965 — **Brewer, Douglas Bertram** Renal biopsy. Baltimore, Maryland, Williams & Wilkins Company, 1965.

RM 121 B6 1968 — **Broman, W. C.** Textbook of pharmacology. Oxford, Blackwell Scientific Publications, 1968.

RA 407.3 C2 1964 — **Campbell, Arthur A.** Natality statistics analysis, United States, 1964. Washington, U.S. Public Health Service, 1967.

RA 407.3 U6 1968 — **Cannell, Charles F.** The influence of interviewer and respondent psychological and behavioral variables on the reporting in household interviews. Washington, U.S. Public Health Service, 1968.

RC 280 .B6 C6 1966 — **Commissie voor Beentumoren.** Radiological atlas of bone tumours. Baltimore, Williams & Wilkins Company, 1966.

RC 440 C7 1967 — **Crawford, Annie Laurie** The work and training of technical and vocational personnel in psychiatric nursing. Atlanta, Georgia, Southern Regional Education Board, 1967.

RD 675 D2 1967 — **Dahlin, David C.** Bone tumors; general aspects and data on 3,987 cases. 2d. ed. Springfield, Illinois, C. C. Thomas, 1967.

RT 71 J6 1967 — **The Johns Hopkins Hospital School of Nursing.** Response to change in health services. Papers from the 75th Anniversary Program of the Alumnae Association, November 3, 1967. Baltimore, The Johns Hopkins Hospital, 1967.

BF 209 .L9 L2 1967 — **LSD, man & society. 1st. edition.** Edited by Richard C. DeBold and Russell C. Leaf. Middletown, Connecticut, Wesleyan University Press, 1967.

Ref. R 713 .29 M4 — **The medieal directory. 1968.** London, Churchill, 1968.

HB 1111 07 1967 — **Ortmeyer, Carl E.** Marriage statistics analysis, United States, 1962. Washington, U. S. Public Health Service, 1967.

R 745 P7 1967 — **Popper, Hans Philipp**
Trends in new medical schools. New York, Grune & Stratton, 1967.

Z 671 P7 1966 — **Progress in library science.**
Washington, Butterworths, 1966.

LB 3051 S3 1967 — **Schaie, K. Warner**
A study of the achievement test used in the health examination surveys of persons aged 6-17 years. Washington, U.S. Public Health Service, 1967.

RJ 52 .S5 1968 — **Shirkey, Harry C.**
Pediatric therapy. 3d. edition. St. Louis, C. V. Mosby Co., 1968.

RD 766 S6 1967 — **Società Italiana di Ortopedia Traumatologia, 52° Congresso, Roma, October 13-15, 1967**
Lesioni traumatiche del bacino. Rome, Società Italiana di Ortopedia e Traumatologia, 1967.

RC 78 U6 1967 — **U.S. National Center for Radiological Health.**
Report of the Medical X-Ray Advisory Committee on public health considerations in medical diagnostic radiology (X-rays), October 1967. Washington, U.S. Public Health Service, 1967.

RC 566 U6 1968 — **U.S. National Library of Medicine. National Medical Audiovisual Center.**
Selected audiovisual listing: Drug Addiction. Atlanta, Georgia, U.S. Public Health Service, 1968.

R 132.5 U6 1968 — **U.S. National Library of Medicine. National Medical Audiovisual Center.**
Selected audiovisual listing: History of Medicine. Atlanta, Georgia, U.S. Public Health Service, 1968.

RA 407.3 U6 — **U.S. Public Health Service. Division of Medical Care Administration.**
Medical care financing and utilization . . . Arlington, Virginia. U.S. Dept. of Health, Education, and Welfare, Public Health Service, 1967.

RA 412.5 U6 U6 1966 — **U.S. Social Security Administration.**
Conditions for coverage of services of independent laboratories. Washington, U.S. Social Security Administration, 1966. (Health Insurance for the Aged HIM-4)

RA 412.5 U6 U6 1966 — **U.S. Social Security Administration.**
Conditions of participation for extended care facilities. Washington, U.S. Social Security Administration, 1966. (Health Insurance for the Aged HIM-3)

RA 415.5 U6 U6 1966 — **U.S. Social Security Administration.**
Conditions of participation for home health agencies. Washington, U.S. Social Security Administration, 1966. (Health Insurance for the Aged HIM-2)

RA 412.5 U6 U6 1966 — **U.S. Social Security Administration.**
Principles of reimbursement for provider costs. Washington, U.S. Social Security Administration, 1966. (Health Insurance for the Aged HIM-5)

R 745 U6 1968 — **University of Oklahoma Medical Center.**
Conference on the use of computers in medical education, April 3, 4, 5, 1968. Oklahoma City, University of Oklahoma Medical Center, 1968.

RC 681 W6 1966 — **World Congress of Cardiology, 5th, New Delhi, October 30-November 5, 1966.**
Symposia. Brussels, Acta Cardiologica, 1966.

RC 840 .G3 W6 1966 — **World Congress of Gastroenterology, 3d. 1966.**
Proceedings: Recent advances in gastroenterology. (v.4 Topical problems in diseases of the biliary tract and pancreas). Tokyo, The Congress, 1967.

RL 26 Y4 1967-8 — **The Year book of dermatology and syphilology. 1967-1968**
Chicago, Year Book Medical Publishers, 1968.



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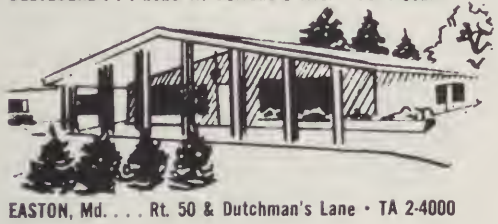
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This advertisement for TAO® (triacetyloleandomycin), published at the request of the Food and Drug Administration, replaces a recent one which the FDA regards as misleading.

The advertisement headlined "new evidence for TAO . . ." and emphasized that the drug is "for the frequently seen respiratory infection in the office and for a problem pathogen* in the hospital. *Staphylococcus aureus."

We emphasize that triacetyloleandomycin is to be used only for acute, severe bacterial infections where adequate sensitivity testing has demonstrated susceptibility to this drug and resistance to other less toxic agents. In view of the possible, but reversible, jaundice and hepatotoxicity of this drug, other less toxic agents should be used unless the organism is resistant to those agents, or in those cases where hypersensitivity precludes their use.

TAO is contraindicated in preexisting liver disease or dysfunction, and in individuals who have shown hypersensitivity to the drug.

The advertisement emphasized that no tooth staining has been reported after ten years of use of this antibiotic. The Food and Drug Administration regards this claim as an implied comparison suggesting that triacetyloleandomycin and tetracycline have a similar antibacterial spectrum of effectiveness, and that TAO has less toxic potential. Any such implication is not intended and, of course, would be invalid.

The advertisement referred to a research study in which patients were given triacetyloleandomycin prior to determining the susceptibility of the offending organism. Any suggestion that triacetyloleandomycin be used clinically without first determining susceptibility of the offending organism should be disregarded.



J. B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017

TAO®(triacetyloleandomycin)
Brief Summary

INDICATIONS: Include streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents.

CONTRAINDICATIONS: Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug.

PRECAUTIONS: CAUTION: USE OF THIS DRUG MAY PRODUCE ALTERATIONS IN LIVER FUNCTION TESTS AND JAUNDICE. CLINICAL EXPERIENCE AVAILABLE THUS FAR INDICATES THAT THESE LIVER CHANGES WERE REVERSIBLE FOLLOWING DISCONTINUATION OF THE DRUG.

Not recommended for prophylaxis or in the treatment of infectious processes, which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgment dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including dark-field examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

ADVERSE REACTIONS: Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions.



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Compilation of Articles on: *The Best of Law and Medicine*

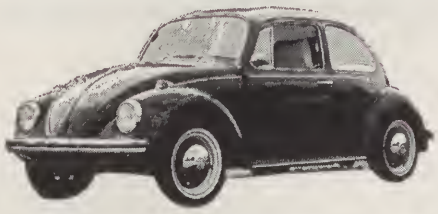
"The Best of Law and Medicine," a compilation of articles appearing in *JAMA* during the period January, 1966, through February, 1968, has been introduced to help familiarize physicians with legal situations with which they may be confronted in their practice.

This collection deals with particular aspects of the impact of law upon the practice of medicine. Demand for reprints of the individual articles became so great that the AMA Committee on Medicolegal Problems suggested that a publication containing the most popular items be produced. The Legal Research Department of the AMA Law Division, which is responsible for content, selected the articles it felt would provide both interesting and useful reference sources for physicians, as well as others interested in this aspect of the law.

Medical liability, medical health and medical evidence represent only a few of the eight major categories covered by the handbook. The 8½"x11", 184-page paperback is *not* intended as a do-it-yourself law book for physicians, nor is it to be considered a substitute for personal legal advice from an attorney.

Residents in the U.S., U.S. Possessions, Canada and Mexico may secure a copy for $1.50. Medical students, hospital interns and residents in these areas may receive it for only 75¢. The price in all other countries is $1.75. Orders should be coded "OP–179" and directed to the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

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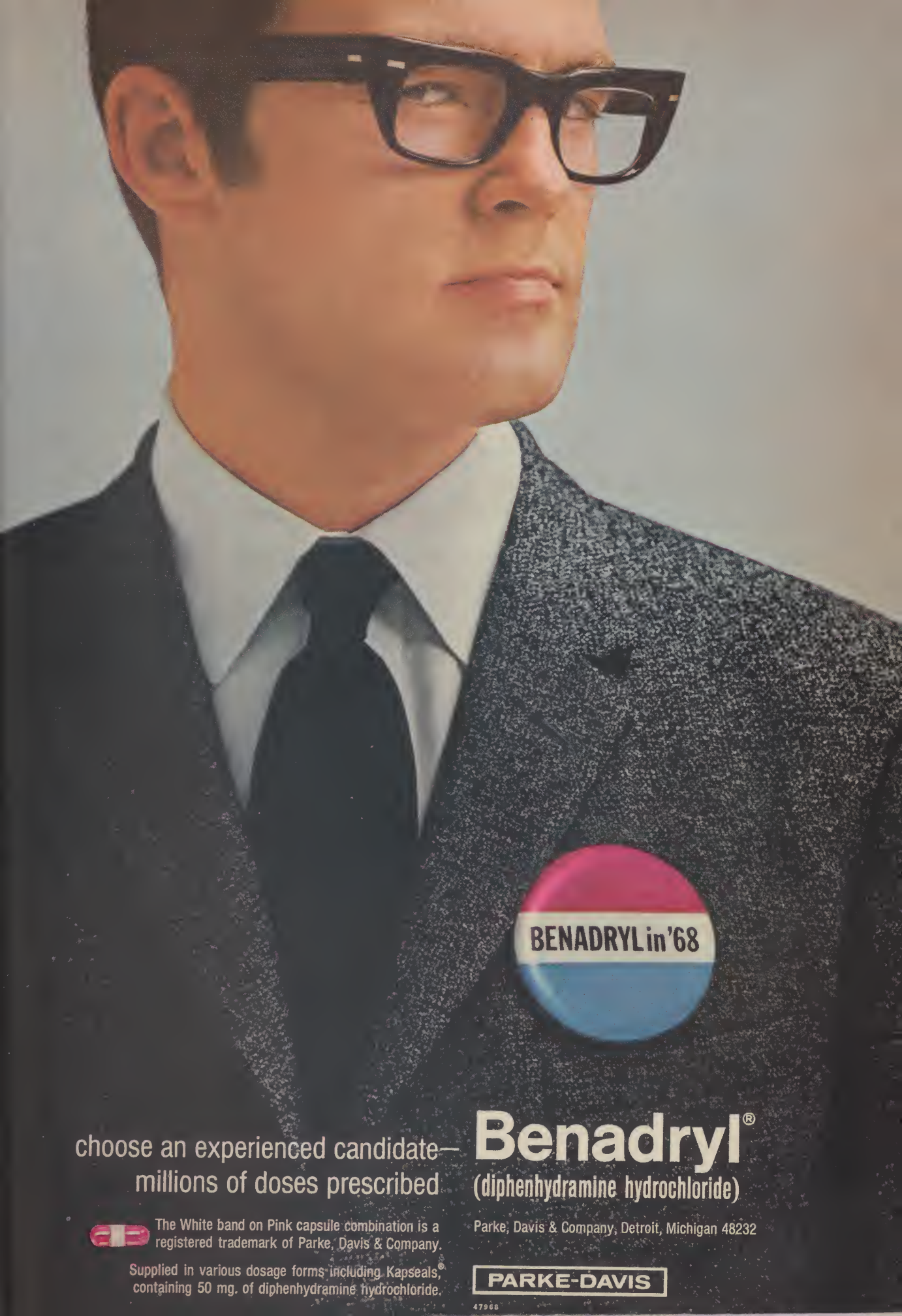
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Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

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Smoking Hazards for Teen-Agers Delineated

As an instructive, cautionary aid to parents, the American Medical Association has published a new pamphlet, "Your Teen-ager and Smoking."

Geared to the parents of teen-agers, the pamphlet provides data on the effect of cigarettes on a smoker's health. It also provides reasons and conclusions why children should not smoke.

A U. S. Public Health Service study, the pamphlet states, concluded that: 1. The teen-age smoker has a much greater chance of dying from lung cancer, chronic bronchitis, emphysema, or coronary heart failure than the smoker who starts later in life, or the non-smoker. 2. The earlier a person starts cigarette smoking, the greater the chances are that he will become a heavy smoker. According to the study, the longer a child puts off smoking, or the sooner he can break the habit, the greater are his chances of avoiding such a fate.

The pamphlet contains helpful hints for parents who want to discourage their children from smoking. It urges parents to avoid taking the "it's too late" attitude and to present the facts about smoking slowly and patiently. It encourages them to set a good example, respect the child's intelligence and try to destroy the romantic images of smoking.

Review copies are available from the AMA's Department of Health Education. Quantity copies are available from Order Handling at 15¢ each; 14¢ each for 50–99; 12¢ each for 100–499; 10¢ each for 500–999; and 8¢ each for 1000 or more.

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Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.

Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.

Usage in Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.

Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.

Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.

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The Month in Washington

President Johnson signed into law the Health Manpower Act of 1968 which extends for two years, until June 30, 1971, and expands the federal programs of aid to medical and allied health schools.

Other health legislation enacted into law: ■ establishes a National Eye Institute as part of the National Institutes of Health; ■ requires federal buildings to provide easy access to the handicapped; ■ authorizes standards to prevent gas lines from leaking and exploding.

President Johnson termed the health manpower law "a major measure in the battle for better health." It authorizes about $1.2 billion in federal aid to medical and other health personnel schools over a two-year period for construction, expansion and operating expenses. Congress followed most of the Administraton's proposals in approving the legislation but limited the extension to two years, instead of the four years requested.

Schools of pharmacy and veterinary medicine were made eligible for the first time.

Money authorizations for schools in the new law:

Medical and other health professions — construction grants, $395 million; institutional support, $285 million; scholarships, $32.8 million; student loans, $70 million; total, $782.8 million.

Nursing — construction, $60 million; institutional support, $75 million; traineeships, $34 million, scholarships, $50 million; student loans, $41 million; total, $260 million.

Allied health (fiscal 1970 only)—construction, $10 million; institutional support, $20 million; traineeships, $5 million; new methods, $4.5 million; total, $39.5 million.

Public health—graduate training, $20.5 million; traineeships, $24 million; total, $44.5 million.

Health research construction, $50 million.

*** *** ***

Both the Democratic and Republican 1968 national campaign platforms cited the importance of the role of private enterprise in the development of government health programs. The GOP placed greater emphasis on private medicine than the Democratic party did.

"While believing no American should be denied adequate medical treatment, we will be diligent in protecting the traditional patient-doctor relationship and the integrity of the medical practitioner," the Republican plank said.

The Republican platform also pledged "to encourage the broadening of private health insurance plans," including extension to cover mental illness.

"Through a partnership of government and private enterprise, we must develop new coordinated approaches to stem the rise in medical costs without lowering the quality or availability of medicare care," the Democratic platform said.

Without being specific, the Democrats indicated support for universal government health insurance or, at the least, wide expansion of medicare or medicaid (or both). Boasting of "giant steps" in the past eight years "in assuring life and health for its citizens," their platform said: "We Democrats are determined to take those final steps that are necessary to make certain that every American, regardless of economic status shall live out his years without fear of the high costs of sickness."

The Democratic health plank also said medical costs should be lowered by more out-of-hospital care, comprehensive group practice arrangements, increased availability of neighborhood health centers, and the greater use of sub-professional aides.

The Republican platform said "inflation produced by the Johnson-Humphrey Administration" was a major factor in the increases in health care costs.

American Medical Association spokesmen appeared before the platform committees of both parties at pre-convention hearings. Dr. Donald E. Wood, Indianapolis, Ind., chairman of the AMA's Council on Legislative Activities, testified at the Republican hearing; Dr. John R. Kernodle, Burlington, N.C., a member of the AMA Board of Trustees, at the Democratic.

Their statements were the same.

The AMA emphasized the desirability of health programs being partnerships among private enterprise and federal, state and local governments. The AMA pledged its support to such cooperative programs for mental illness, infant mortality, occupational health and safety, and education of physicians and allied health personnel.

Concerning health care costs, the AMA said: "We believe that programs to increase the production of medical and other health personnel can be cooperatively and effectively undertaken. We are further firmly convinced that we can and must work toward comprehensive health-care system in the inflationary spiral, and toward a productive use of tax dollars expended in the health area. New and old tax supported programs in the health field should be critically evaluated so that while the best health care is attained, overlapping, waste and unnecessary programming are avoided. In this regard, we recommend the establishment of a cabinet-level Department of Health, headed by a physician as Secretary, with overall responsibility for all federal health programs, so that maximum effectiveness may be attained.

"We have always maintained that high-quality medical care should be available for all Americans, including those who need assistance in meeting the costs of such care . . . . Firmly convinced that adequate health insurance coverage is the choice mechanism for the financing of quality health care costs, we suggest that the country embark on a program of tax credits for health insurance premiums. Under such a plan, all individuals and families would be encouraged to provide themselves with health care cost protection, with those in financial need receiving the greater amount of tax credit on a graduated basis."

*** *** ***

The Food and Drug Administration and the Pharmaceutical Manufacturers Association differed as to the significance of the findings of a Georgetown University School of Medicine research team after studies comparing three brand-name drugs with their generic versions.

Drugs tested were diphenylhydantoin, prescribed for treatment of epilepsy, chloramphenicol and sulfisorazole. The studies supported by the FDA showed:

- Some generic drugs are absorbed more slowly by the body than the brand;
- At least one generic drug was absorbed faster by the body than the brand drug;
- Absorption rates were governed by such factors as crystal size of the drug, hardness of tablets, and the types of drug capsules.

"Our findings raise serious doubts about the equality of different products of the same drug in the treatment of disease," said Christopher M. Martin, MD, Professor of Medicine and Pharmacology.

"The studies by Dr. Martin and his research team, showing how different versions of the drug behave differently in man, provide further proof of the scientific fact that these differences can be significant in patients," C. Joseph Stetler, PMA President stated.

"Clearly, there is no evidence to indicate that all formulations of the same drug are equivalent. From all the evidence that has been developed to date, as Dr. Martin's studies point out, quite the opposite may be true."

On the other hand, **FDA Commissioner Herbert Ley, Jr., MD,** said his agency "has in no sense concluded that 'generic' drugs are less effective as a class than 'brand-name' products. . . .

"In my opinion, there are fewer than two dozen drugs where therapeutic differences among competing products may be a problem," he said.

"Data from the Georgetown work have been useful to the FDA, but it is completely unwarranted to reach any general conclusions about drug equivalency on the basis of these exploratory studies."

*** *** ***

A retired air force officer, Maj. Gen. Theodore C. Bedwell, Jr., MD, 59, has been appointed to the newly-established post of chief medical officer for the medicare program. He will be liaison with the medical profession.

He most recently was director of staff, office of the deputy assistant secretary of defense (manpower—health and medical). A native of Texas, he was graduated from Baylor University Medical College.

A holder of the distinguished service medal, Dr. Bedwell in 1962 received the American Medical Association's special aerospace medicine honor citation.

Chloromycetin (Chloramphenicol): A "Fall Guy"!

JOHN F. SCHAEFFER, MD
Baltimore

Every Physician in this state is alerted to the fact that a threat is posed to his freedom to prescribe a drug which in his opinion is the best medicine available for the particular problem presented by his patient. LEGISLATION RESTRICTING THIS FREEDOM IS BAD!

The Judicial Proceedings Committee of the Legislative Council held hearings, the first week of September, to consider the advisability of recommending legislation to legally control, perhaps even prohibit, the prescribing of Chloromycetin *and other toxic drugs* by physicians.

Chloromycetin is the "Fall Guy" in these hearings. This drug, when properly used, has cured patients who would have died without it. Typhoid fever and the rickettsial diseases respond to this drug more effectively, more rapidly, than to any other antibiotic. In hospital practice, when culture and sensitivity tests indicate that this drug is the drug of choice, the physician and surgeon thanks his particular god that it is available, and uses it.

Parke-Davis and Co., manufacturer of Chloromycetin, would have it no other way. In their descriptive brochure they point out that "the drug should not be used when other less potentially dangerous agents will be effective, that it must not be used in the treatment of trivial infections such as colds, influenza, and throat infections."

The Committee of the Legislative Council can hear from, and perhaps be swayed by, individuals who have alledgedly had a family member killed or harmed by Chloromycetin—for the Committee's consideration, evidence is abundant regarding Penicillin, the most used antibiotic in the world, and lethal, toxic, and disabling effects from its use—yet Penicillin is the most valuable antibiotic ever discovered and, when given in controllable dosage, is the greatest boon to the sick mankind has ever produced.

This Committee of the Legislative Council must realize that legislation against *any* drug is the wrong approach. Medicinal prescribing by a physician cannot be legislated, any more than morality can. Prohibition was a ghastly example of law which increased rather than decreased the consumption of a drug *Spiritus Frumenti,* commonly called "booze". No legislator wants to repeat this experiment, with other drugs. Chloromycetin is not alone for consideration—*toxic drugs generally* are included for discussion. Every physician at sometime or other has seen or will see the very occasional patient that a 5-grain aspirin tablet will kill.

There is an imperative need for all physicians to be fully informed regarding the effects of the drugs they prescribe. In a recent survey by the Pharmaceutical Manufacturers Association, 64% of physicians stated they were satisfied with current sources of prescribing information, particularly the *Physician's Desk Reference;* 21% reported that existing sources of prescribing information should be revised or expanded; and 15% believed that an entirely new compendium of prescribing information is needed. As a result of the survey, the Association will make specific proposals including suggested revisions in the Desk Reference and in other major compendia as well.

The Committee of the Legislative Council, and all physicians, should agree with these conclusions:

- All drugs are toxic, or potentially toxic.
- All drugs have contraindications, situations in which they should not be used.
- The responsibility for treating each individual patient for a specific infection, or other disease, rests completely with the treating physician.
- The drug which the physician elects to administer represents in his judgment the best drug available for the particular problem presented.
- The physician must be prepared to justify his choice of drug for the particular case, and be prepared to defend his choice in court, if resultant effects are toxic or incapacitating, alledgedly because of his ignorance, or negligence in not being fully informed of the drug's side-effects or contraindications.

Drugs of Abuse

Identification of Controlled Drugs: In general, the abuse of depressants and stimulants involves drugs that have been diverted from legitimate channels of distribution. The more popular brand name depressant or stimulant drugs bear trademarks or other identifying symbols. Presumptive visual identification is often possible because of the distinctive colors, shapes, or markings of the trade name drugs. However, many controlled drugs have no specific identifying characteristics and may be similar in appearance to many noncontrolled drugs. Laboratory analysis is therefore necessary for the positive identification of controlled drugs.

Stimulants—Why Taken: The Stimulants act directly on the central nervous system. They produce a feeling of excitation which manifests itself in appetite loss, increased activity with a feeling of energy, and the ability to go without sleep for prolonged periods. During these periods the victim's body uses up its reserve of energy which may eventually cause the mind to "black out." Highway accidents may be the result of drivers using these drugs. The stimulants are often relied on by criminals to increase their nerve. They may be the cause of reckless behavior in juveniles. The body develops a tolerance to these drugs and abusers increase their dosage, exaggerating the normal effects. ● The abuser may exhibit restlessness or nervousness, with tremor of hands, dilated pupils, dryness of

mouth, and heavy perspiration. He may be talkative and have delusions and hallucinations if he has used a large quantity. In the serious cases, amphetamines cause a psychosis which may resemble paranoid schizophrenia. In short, the person abusing stimulants may exhibit dangerous, aggressive behavior with antisocial effects. The stimulants are usually taken orally; however, the mainlining of these drugs is also encountered.

Depressants—Why Taken: The barbiturates and tranquilizers depress the central nervous system to relieve tension or produce sleep. They are abused for the alcohol-like euphoria they give. Barbiturates and alcohol taken together can, and have caused accidental death. Tranquilizers are sometimes used to "come down" from hallucinogens or stimulants. Depressants are both physically and psychologically addicting. Withdrawal from addiction to barbiturates can be more dangerous than withdrawal from the opiates.

- The abuser of depressants will exhibit the common symptoms of drunkenness but there is no odor of alcohol unless both have been taken. A small amount of the drug makes him believe he is relaxed, sociable, and good-humored. The drug makes him less alert and slower to react. Increased doses cause sluggishness, depression, and for some users a quarrelsome disposition. The tongue thickens and speech becomes slurred and indistinct. There is a loss of physical coordination which may be accompanied by mental and emotional instability. The user may slump into a deep sleep or a coma depending on how much of the drug has been taken. Overdosage is common because the abuser may forget how much of the drug he has already consumed. Barbiturates are frequently the cause of intentional and accidental suicides.

The Hallucinogenic Drugs: In illicit channels of distribution these drugs originate from clandestine laboratories. They have no standard dosage forms or markings that make visual identification possible. The hallucinogenic drugs may be encountered as homemade capsules or tablets. They may also be encountered as nondescript powders or liquids. The physical properties of the hallucinogenic drugs are such that they can be easily disguised as various powders or liquids commonly found on the person or in the household. These drugs are frequently applied to common objects. LSD, for example, has been encountered on sugar cubes, chewing gum, hard candy, candy mints, crackers, wafers, blotter paper, postage stamps, handkerchiefs, aspirins, vitamins, antacid tablets, beads and other personal jewelry.

Hallucinogens—Why Taken: The hallucinogenic drugs have been irresponsibly promoted as a means of expanding consciousness. Some promoters who openly urge such use have adopted the slogan "Turn On—Tune In—and Drop Out." The abuse of such drugs has also been part of a more subtle promotional theme involving "rock and roll" music, psychedelic books, magazines, and newspapers. Use of these drugs is considered the "in" thing to do. Youths are especially susceptible to the current glamorization of drug-taking by nonconformist groups. Since adolescence is a stage of experimentation and "finding one's way" in life, youngsters may find the urge to "try" drugs attractive.

- When the user takes hallucinogenic drugs, he experiences distortion and intensification of sensory perception with lessened ability to discriminate between fact and fantasy.

These users often speak of seeing sounds, tasting colors, etc. There is a dilation of the pupils and dark glasses are often worn, even at night. The user may be restless with an inability to sleep until the drug wears off. He may, however, exhibit no noticeable physical signs of drug intoxication. The mental effects are quite unpredictable, but may include illusions, panic, psychotic or antisocial behavior, and sometimes impulses toward violence and self-destruction.



Marihuana

After careful appraisal of available information concerning marihuana (cannabis) and its components, and their derivatives, analogues and isomers, the Council on Mental Health and the Committee on Alcoholism and Drug Dependence of the American Medical Association and the Committee on Problems of Drug Dependence of the National Research Council, National Academy of Sciences, have reached the following conclusions:

- **Cannabis is a dangerous drug and as such is a public health concern.**

For centuries, the hemp plant (cannabis) has been used extensively and in various forms as an intoxicant in Asia, Africa, South America, and elsewhere. With few exceptions, organized societies consider such use undesirable and, therefore, a drug problem, and have imposed legal and social sanctions on the user and the distributor.

Some of the components of the natural resins obtained from the hemp plant are powerful psychoactive agents; hence the resins themselves may be. In dogs and monkeys, they have produced complete anesthesia of several days' duration with quantities of less than 10 mg/kg.

Although dose-response curves are not so accurately defined in man, the orders of potency on a weight (milligram) basis are greater than those for many other powerful psychoactive agents, such as the barbiturates. They are markedly greater than those for alcohol. In India, where weak decoctions are used as a beverage, the government prohibits charas, the potent resin, even for use in folk medicine. In many countries where chronic heavy use of cannabis occurs, such as Egypt, Morrocco, and Algeria, it has a marked effect of reducing the social productivity of a significant number of persons.

and

The fact that no physical dependence develops with cannabis does not mean it is an innocuous drug. Many stimulants are dangerous psychoactive substances although they do not cause physical dependence.

- **Legalization of marihuana would create a serious abuse problem in the United States.**

The current use of cannabis in the United States contrasts sharply with its use in other parts of the world. In this country, the pattern of use is primarily intermittent and of the "spree" type, and much of it consists of experimentation by teen-agers and young adults. Further, hemp grown in the United States is not commonly of high potency and "street" samples sometimes are heavily adulterated with inert materials.

With intermittent and casual use of comparatively weak preparations, the medical hazard is not so great, although even such use when it produces intoxication can give rise to disorders of behavior with serious consequences to the individual and to society.

And, while it is true that now only a small proportion of marihuana users in the United States are chronic users and can be said to be strongly psychologically dependent on the drug, their numbers, both actual and potential, are large enough to be of public health concern.

If all controls on marihuana were eliminated, potent preparations probably would dominate the legal market, even as they are now beginning to appear on the illicit market. If the potency of the drug were legally controlled, predictably there would be a market for the more powerful illegal forms.

When advocates of legalizing marihuana claim that it is less *harmful* than alcohol, they are actually comparing the relatively insignificant effects of marihuana at the lower end of the dose-

response curve with the effects of alcohol at the toxicity end of the curve—ie, the "spree" use of marihuana *vs* acute or chronic "poisoning" with alcohol. If they compared both drugs at the upper end of the curve, they would see that the effects on the individual and society are highly deleterious in both cases.

Admittedly, if alcohol could be removed from the reach of alcoholics, one of the larger medical and social problems could be solved. But to make the active preparations of cannabis generally available would solve nothing. Instead, it would create a comparable problem of major proportions.

That some marihuana users are now psychologically dependent, that nearly all users become intoxicated, and that more potent forms of cannabis could lead to even more serious medical and social consequences—these facts argue for the retention of legal sanctions.

- **Penalties for violations of the marihuana laws are often harsh and unrealistic.**

Persons violating federal law with respect to possession of marihuana are subject to penalties of from 2 to 10 years imprisonment for the first offense, 5 to 20 years for the second offense, and 10 to 40 years for additional offenses. Suspension of sentence, probation, and parole are allowed only for the first offense. Many of the state laws provide for comparable penalties. With respect to sale, penalties are even more severe.

Laws should provide for penalties in such a fashion that the courts would have sufficient discretion to enable them to deal flexibly with violators. There are various degrees of both possession and sale. Possession ranges from the youngster who has one or two marihuana cigarettes to an individual who has a substantial quantity. Sale may range from the transfer of a single cigarette to the disposition of several kilograms of the drug.

While persons should not be allowed to become involved with marihuana with impunity, legislators, law enforcement officials, and the courts should differentiate in the handling of the occasional user, the frequent user, the chronic user, the person sharing his drug with another, and the dealer who sells for a profit.

Society

Of particular concern is the youthful experimenter who, by incurring a criminal record through a single thoughtless act, places his future career in jeopardy. The lives of many young people are being needlessly damaged.

For those persons who are chronic users of the drug, and are psychologically dependent on it, general medical and psychiatric treatment, plus social rehabilitative services, should be made readily available. Such persons should not be treated punitively for their drug abuse alone any more than are persons dependent on other drugs, such as narcotics or alcohol.

Furthermore, if the purpose of imposing penalties is to deter acts which might injure the individual and disrupt society, then equitable penalties, insofar as they enhance respect for the law, can contribute to effective prevention.

- **Additional research on marihuana should be encouraged.**

Only recently has an active hallucinogenic principle of cannabis been exactly identified and synthesized. Sufficient time has not elapsed to obtain a substantial body of pharmacologic and clinical evidence concerning its effects. There are no carefully controlled clinical studies of

long-time effects of cannabis on the central nervous system or other organ systems. These and other considerations point to the importance of ongoing research in this area.

It must be emphasized, however, that the issue which faces the United States today is not whether we know all there is to know about marihuana scientifically. Obviously every effort should be made to correct the deficiencies in our knowledge. The issue is whether we can ignore the experiences and observations established over centuries of heavy use of hemp preparations in various societies. A current solution to the problem does not relate to what is not known, but to those facts which are known about cannabis and its preparations. There is extensive experience in its use in all of its forms, including the effects of the potent natural resins which contain the active biological principles.

- **Educational programs with respect to marihuana should be directed to all segments of the population.**

Educational material, based on scientific knowledge, should point out the nature of marihuana and the effects of its use. Such material should be an integral part of a total educational program on drug abuse.

Primary and secondary schools, as well as colleges and universities, should establish such programs.

The communications media should disseminate authoritative information to the general public.

Physicians, as professional practitioners and concerned members of the community, should call attention frequently and forcibly to the problems of drug abuse and drug dependence.

An informed citizenry, in the final analysis, is the most effective deterrent of all.

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Drug Dependence: Its Significance and Characteristics

"Drug dependence of the cannabis type is a state arising from chronic or periodic administration of cannabis or cannabis substances (natural or synthetic). Its characteristics are:

● Moderate to strong psychic dependence on account of the desired subjective effects. ● Absence of physical dependence, so that there is no characteristic abstinence syndrome when the drug is discontinued. ● Little tendency to increase the dose and no evidence of tolerance. For the individual, harm resulting from abuse of cannabis may include inertia, lethargy, self-neglect, feeling of increased capability, with corresponding failure, and precipitation of psychotic episodes. Abuse of cannabis facilitates the association with social groups and sub-cultures involved with more dangerous drugs, such as opiates or barbiturates. Transition to the use of such drugs would be a consequence of this association rather than an inherent effect of cannabis. The harm to society derived from abuse of cannabis rests in the economic consequences of the impairment of the individual's social functions and his enhanced proneness to asocial and antisocial behavior."[1]

1. Eddy, N. B., et al.: Drug Dependence: Its Significance and Characteristics, Bull. WHO 32:721-733 (No. 5) 1965.

OUR TURBULENT YOUTH

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Our turbulent youth live in a turbulent world.
If we consider the unpopular war, the economic troubles of our nation, crime in the streets, and the racial problems with almost uncontrolled burning and looting in our cities, we can understand why the youth of today doubt the abilities of their elders to handle our nation's problems. Thus, their confidence is shaken by the logic of parental decisions.

A discussion of the problems of turbulent youths includes many subjects. Venereal disease; pregnancy and suicide; hippies; drug abuse; and parental permissiveness are just a few.

In our world of today, there are three hundred million adolescents. By 1970, half the population of the United States will be under 25 years of age. It is estimated that at the current birth rate, our population will double by the year 2000. Statistics further tell us that the growth rate of the teen-age population is four times as high as the general U.S. average rate, with twenty-four million people between 13 and 19 years of age in our country.

Our teen-agers spend twelve billion dollars per year in our economy. Of this, 1.5 billion is spent on entertainment and 3.6 billion for female attire. Our youths account for 25% of the hi-fi and stereo record sales.

In the United States in 1900, only 13% of the adolescents were students in our high schools and colleges. By 1940, this figure jumped to 73%. Now, 95% attend high school with more than half these graduates entering college.

It is easy to indict the youth of today for the riots that occur, the unwed pregnancy rate, and the rising venereal disease rate. Our youth is called the "have" generation by the "have not" generation. Let's stop and think over the following facts and see who is to blame.

The illegitimacy rates are rising, especially in the white race. Between 1940 and 1963, the white illegitimacy rate rose 55% while the Negro rate rose about 40%. The increase in the case of whites was from 2% to 3.1% of all births, and for Negroes, from 16.8% to 23.6.% The reasons given for the lower rate in the white race is that money for abortions is more available, as is knowledge of birth control methods. Adoptions in the white race are higher, with about three out of four babies being adopted, while in the Negro race, only one out of ten babies is adopted.

On the national level, the U.S. National Council on Illegitimacy reported over 250,000 illegitimate births a year, of which 90,000 occurred in teen-agers. This annual number among adolescents has more than doubled in the past 20 years. It might also be noted that teen-age girls have more obstetrical problems and a higher infant mortality in their babies. It is difficult to assess the psychological and mental trauma.

Frank J. Ayd, MD, of Baltimore, Maryland, states in his article, "Contraceptives for Teen-agers," **"Most MD's hold a conservative position and do not favor providing contraceptives for single teen-agers. It is not contraceptives that they need, but a complete emotional reeducation to protect them from cheap and unsatisfying adventures, and against the self-punishment of pregnancy."**

The rising venereal disease rate among teen-agers is frightening. Gonorrhea and infectious syphilis occur most frequently in the 10- to 24-year-old group and account for 50% of the reported new cases of infectious syphilis in the United States. A like comparison has been noted by a study prepared by the World Health Organization in the period from 1957 to 1960, stating that teen-age syphilis increased from a low in Canada of 19% to a high in Denmark of 85% of reported new cases.

The "New Morality" is widespread indulgence, often referred to as the teen-age "copulation explosion." There has been a drop in the age of first experiences of sexual activity which often occurs between 12 and 16 years of age. Fernando-Henriques claims, **"There has been a revolt of youth against the sexual moral code of its elders."** This is further confirmed when we realize that venereal disease infects more than 250,000 of our young Americans annually. The reasons for its prevalence among teen-agers, is that those in the metropolitan areas have: ■ less parental and adult supervision; ■ more cash; ■ more free time; ■ cars to drive; ■ access to salacious literature; ■ alcohol; and, ■ changing attitudes toward sex, religion, and morality.

What can parents do to prevent these heartaches in their offspring? ■ **Keep open the lines of communication.** ■ **Know where they are going, with whom, and when they can reasonably be expected to return.** ■ **Do not give permission for unchaperoned parties.** These sound like simple rules, but they require patience and wisdom to set the limits of enforcement with youth.

Suicide Among Adolescents

A study done in the University Hospital of the University Medical Center, Cleveland, Ohio, in 1968, states that suicide is an increasing problem among adolescents in the last decade. It is the fourth leading cause of death in the 15- to 19-year-old group in the United States. In 1963, Kurt Glaser, MD, of the University of Maryland, concluded that four out of every 100,000 deaths in the U.S. are due to suicide among teen-agers. Japan has a rate of 26% due, it is thought, to the conflict between the adolescent and his family.

The age-old Japanese culture decides whom the adolescent is to marry and what career he is to follow. (There is also a romantic tradition in Japan that death by suicide is a beautiful gesture.)

Austria has a suicide rate of 11.7%; Sweden, 6%. It is felt that in the U.S., the reasons for suicide are emotional stress, sometimes originating from adult pressure at home or at school. Also, middle-class families are moving to better neighborhoods and striving for higher social and economic status. The adolescent has a psychological drive for independence and he may develop hostility toward his elders with resultant death-wishes toward his parents. These feelings are acted out with suicide attempts. These attempts are cries for help when he feels his family has failed him. Or, he may develop assaultive or destructive behavior, marked anxiety or fears, actions which are considered bizarre and confused, school refusal or truancy.

Threatened suicides should be handled by the psychiatric emergency service and a clear explanation of the factors that provoked the suicide attempt should be given to the family. The treatment plan should involve the parents, with specific directions for immediate alleviation of the child's distress.

The warning signs of suicide include mood changes (shyness), neurological symptoms, temper tantrums, hallucinations (hearing voices), anxiety, depression, change in school performance, or withdrawal from friends.

Dr. Ulf Otto of Sweden studied the methods of suicide in adolescents and concluded that the most common were ingestion of drugs and violence. The latter was more frequent among males. The reasons given for suicide are: ■ love problems; ■ family problems; ■ military service; and, ■ pregnancy. Adolescent suicides are highest in the month of November and lowest in June and July.

Other causes of death are: motor vehicle accidents, 38.6%; other accidents, 18.4%; malignant neoplasms, 8.4%; cardiovascular disease, 4.9%; suicide, 4.4%; pneumonia, 2.3%; other, 23%.

A recent article in a national student magazine titled *Moderator,* states: "We're pushing our kids too hard—from nursery school to graduate school. Children develop and learn at different rates. Our high school competition is wide open and frantic. College brings no relief from the competition, and graduate school is even worse." As many as one out of ten college students has an emotional problem serious enough for psychiatric help.

Dr. Graham Blaine of Harvard states that **"underachievement is probably the most subtle and insidious form of adolescent rebellion."** Pressure is one of the reasons why young people become estranged from their families and rebellious against all authority. They proclaim their freedom, smoke pot, take drugs, and turn hippie.

Hippies

Hippie—This term is derived from the jazz term, "hip," meaning aware, sharp, or in tune. The hippie accounts for the major portion of an 18% increase in missing persons in the last two years. They are a rebellious lot, emotionally shaken, and looking for values they can't find at home. They want to do the things they like and not do the things they don't like. They congregate in such places as East Village, New York; Haight-Ashbury, San Francisco; or, Sunset Strip, Hollywood, California.

There are some lessons in the hippie philosophy which might be of value in the lives of the so-called "Establishment" or "squares," the parents of the "Flower Children." For instance, they have feelings of appreciation for nature, art and music, and a love of their fellow man; also, they shun the materialistic things of life.

There is, however, a brutal side to the hippie which is evidenced in the case of Linda Fitzpatrick, an 18-year-old from Greenwich Village, and a boyfriend, "Groovy" James Hutchison, 21 years old. They were beaten to death after experimenting with drugs and sex. These adolescents, as well as most others who embrace this way of life, were from affluent homes in the upper middle class. There are almost as many girls as boys who embrace the cult. The problems and attitudes of the hippie are similar to the ones that we face in treating our youth in general. After all, our children accept hippie hairstyles, hippie clothes, and hippie music.

Lary M. Abrahamson, MD, who practices in Haight-Ashbury, feels that there are three types of hippies: the real hippie, the pseudo hippie, and the week-end hippie. He defines the real ones as those who wear beards and mustaches but cut their hair. They are distinguished by what they have to say and how they act. They have a cold attitude, are straightforward, and are definitely not part of the "Establishment." They seem to feel sorry for the doctor in his professional world.

The pseudo hippie is infantile, rebellious, wears outlandish clothes, takes drugs indiscriminately, and easily becomes addicted. His attitude toward the physician is one of resentment. The week-end hippie is the college student who mixes with the hippies in his off-time and goes back to college again to finish his studies.

The hippies have a language all their own and it is helpful to the physician to understand this language so as to have a meeting point with his youthful patient. However, it is not wise for him to attempt to speak it himself.

There have always been angry young men in our civilization. They were called the "lost generation" following World War I; the "Depression generation" in the thirties—pinkos, radicals, or Communists. The 1950's produced the "beatniks"; the 1960's, the rebels who protest such things as discrimination. Viet Nam, and campus regulations.

Hippie characteristics include suspicion of the "Establishment", rejection of competition for materialistic things, and rejection of the struggle involved in living a life they find meaningless. They feel that mankind is involved in massive insanity. They want to live communally, smoke marihuana, and many take LSD and other mind-expanding drugs.

A study in Haight-Ashbury by H. Taylor Buchner, who lived with the hippies, concluded that 25% or more share quarters with ten or more persons. Sixty percent of the hippies are between 16 and 21 years of age and only 2% are above 30 years of age. Sixty-nine percent are employed—many in the U.S. Postal Service. Seventy percent come from outside California. Ninety-six percent smoke marihuana at some time, and 90% have taken LSD.

Appearance is important to the adolescent. He wishes to conform but has a feeling of being marginal and isolated in relation to society. He may even feel isolated in respect to himself or his own family. The hippie has this state intensified to the point where his needs are out of harmony with the "Establishment". He feels depersonalized in the world of business or the university. He has no personal identity, so he becomes a hippie. He wishes to have a total freedom of self; no count of time. He lives only for today. Frequently, he prefers hunger to the routine of daily work, and he is unable to cope with the pressure, responsibility, and involvements that living in the Western world entails.

Our healthy adolescent will outgrow hippie-time; the neurotic ones will continue to protest. It is difficult for parents to adopt a "wait-and-see" attitude toward their offspring in the hope that they will outgrow the hippie influence, but it is the only practical path.

Drug Abuse

An acid voyage breaks down the ego and "lifts the veil of illusion to show holiness and oneness of the universe," according to a *Medical Science* editorial. The youth of today achieve psychedelic experiences through hallucinatory drugs, marihuana, religion, or sex. Many times they harm themselves by indiscrete drug usage without any real scientific background.

"The pursuit of Hippiness is home in Haight-Ashbury, where never is heard a disparaging word, and the mind is quite clouded all day."

Psychedelic is defined as mind-manifesting. Presently, the most popular way of obtaining this effect is the use of LSD which is d-lysergic acid diethylamide.



LSD was discovered accidentally in 1943 by the Swiss chemist Albert Hoffman. It is absorbed rapidly from the gastrointestinal tract and appears in the bile and plasma where it is bound to proteins. It is metabolized in the liver. LSD effects the peripheral autonomic nervous system as well as the central nervous system. It causes a slight dilatation of the pupils, an increase in the heart rate, a rise in blood pressure, a rise in the blood-sugar level, and an increase in the knee-jerk reflexes. It also produces a distortion of the sense of perception. Visions may occur, dream images, and also a psychotic state going from euphoria to anxiety and depression. A very unusual phenomenon of reappearance of hallucinations may occur as long as weeks or months after stopping the drug.

LSD has been suggested in: ■ the treatment of psychotic conditions resistant to psychotherapy; ■ chronic alcoholism; ■ chronic neuroses; and, ■ relief of severe pain in terminal malignant states.

The dangers of LSD are: ■ prolonged psychotic episodes following administration; ■ anxiety and panic reactions; ■ induction of a persistent state of altered consciousness such as fear, violent rages, homicide; and, ■ high numbers of broken chromosomes in the leucocytes of infants whose mothers have ingested LSD.

Dr. José Egozcue, director of genetic studies at the Oregon Regional Primate Research Center in Beaverton, Oregon, states that the babies did not appear abnormal in any way other than the broken Philadelphia-like chromosomes. It is not known whether these abnormalities are temporary or lasting, since it depends on whether cells other than leucocytes are affected. A single dose of 300 μg or more of LSD can produce this chromosomal abnormality.

LSD may be taken on sugar cubes, on animal crackers, in a liquid form, a capsule, small white pill, or ampules of liquid for intravenous administration. The cost is staggering. The alleged street price is $1 for 25 μg or $40 for 1 mg. This compares with radium which is $20 for 1 mg or morphine which is 40¢ for 1 mg. The slang names for LSD are "the beast," "25," "the hawk," "the chief," "the ghost," or "crackers."

The psychedelic effect is greater on the emotionally unstable and psychopathic personalities, and these are the ones who are attracted to its use. Twenty-four states in the United States have laws prohibiting the possession of LSD and a law is now in Congress to make possession a federal misdemeanor, punishable with a $1,000 fine and up to one year in prison. Methedrine and phenobarbital are being considered in the same category.

Marihuana, or marijuana, was recorded in Chinese literature 2,000 years B.C. Cocoa leaves have been chewed by the South American Indians for centuries, and the Indians of our own Southwest used peyote, a cactus part, for their religious services. The marihuana of today is derived from the flowery top of the hemp plant which is dried and powdered, then rolled into a cigarette. These are called "reefers," "grass," or "pot." Marihuana produces a feeling of well-being, and sensory distortions. The inhalation of the cigarette smoke is pleasant. The usual reason for taking it is to produce a psychic effect. It also produces a psychic dependence on the drug.

The use of marihuana is illegal to date. "Pot Head" parties are held by college students frequently as the "thing to do." This is their form of rebellion against authority. Frequently, the user turns to LSD or heroin for more intense reactions.

Hashish, a stronger cousin of marihuana, is grown in Africa and the Middle East. This drug may cause physical and mental changes and may interfere with social and economic productivity. Very often the user will miscalculate time and distance, which can be very hazardous while driving a car. Users neglect their personal appearance and tend to become listless. Furthermore, they go without food and become undernourished. Often, these users will wear dark glasses, even at night. A final step may be the switch to heroin. This is sometimes injected into the veins (called "mainlining"), and may produce septicemia, hepatitis, or tetanus.

In the United States there are 60,000-120,000 drug addicts. Ninety percent of these take heroin. Medical complications resulting from drug abuse are listed in the *Annals of Internal Medicine,* July, 1967:

1. **Embolic pneumonia.**
2. **Upper respiratory infections with acquired pneumonia.**
3. **Lung absesses.**
4. **Pulmonary fibrosis or granulomatosis from talc and cotton fibers.**

5. **Overdose, producing rapid respirations, cyanosis, and pulmonary edema.**
6. **Unsterile needles producing hepatitis, tetanus, malaria, thrombophlebitis, cellulitis, and bacteremia.**

The treatment for heroin addiction is the narcotic antagonist, cyclazocine, and rehabilitation.

Methadrine is the chemical name for methamphetamine, also called "pep pills," "speed," "jolly beans," or "crystal." The drug user may sniff it as a concentrated liquid or take it intravenously, using as much as 500 to 1,000 mg. This produces a paranoid psychosis, organic syndromes, and euphoria. This "chemical joy" can produce potential dangers which are not all known at the present time.

Cocaine is now beginning to appear more frequently on the American black market, and, more recently, amantadine, the newly developed antiviral chemoprophylactic which is also being used as an hallucinogenic agent. The latter is pharmacologically similar to LSD and produces a like effect.

Another new drug, **STP,** which is 2.5 dimethoxy-4-methyl-amphetamine, is also appearing on the market for hallucinogenic effect. The "STP" stands for Serenity, Tranquility, and Peace.

Dr. Sidney Cohen in *Medical Science,* February, 1968, states, **"The misuse will recede eventually, but not until many valuable people have been psychologically, physically, and socially impaired."** Other than limiting the supply of drugs, education, to convince young people of the immense risks of untoward reactions and infection which may result in irreparable physical damage or even death, is the only solution to drug abuse.

Parental Permissiveness

Our society has changed rapidly and markedly since World War II. Our standards of living have gone up and many families have two cars. We are now reaping the questionable benefits of the overpermissive parents who have doted on their youngsters, giving them many of the material things which they never had themselves, and permitting unrestricted behavior.

Our "Affluent Society," characterized by a lack of morals, and preoccupation with monetary and material well-being, has produced a generation of rebellious youth. Many high school and college students now have cars of their own. For instance, Iowa State University, with a student body of 15,000, had to provide parking spaces for 7,234 cars in 1966.

> According to *Therapeutic Notes,* October, 1966, the five most frequently diagnosed emotional problems of adolescents are: 1) adjustment reactions to adolescence, 2) behavioral problems, 3) personality problems and trait disturbances, 4) psychoneurotic reactions, and, 5) scholastic failure. Parents say, "I can't do a thing with him," and yet, they have allowed their child to do pretty much as he pleases. "All the books say I shouldn't spank him!"

Our society is not all bad. We have definite prohibitions against transgressing against the rights of others. Our children must learn the rules of living early in life. If the parent gives unconscious encouragement to questionable activities and attitudes, this may actually encourage asocial behavior.

An example of this would be a young child going into a shop with his parents and taking something without paying for it. When the parent discovers this at home and does nothing about it, the child accepts this as getting away with a delinquent act. Actually, the parent should immediately take the child back to the store's manager to return the stolen article, no matter how small or inexpensive. Then, there is the father who has outwitted someone in a slick business deal of shady character. Coming home, he brags about it in front of his family, and the child unconsciously absorbs and accepts this as proper behavior.

Conscience is developed during the first six years of life by identification, in great detail, with parental behavior. Prohibitions are an important aspect of the child's security. The adolescent, particularly, wants to have limits set for him. Cultural prohibitions still hold today in spite of our affluent society. Murder, arson, theft, and sexual destructiveness are wrong in our basic culture. With major problems, therapy involves intensive treatment of the parents and the adolescent.

In conclusion, adolescent turmoil can be identified with:

- our increasing venereal disease rate caused by relaxed moral codes and less parental supervision;

- illegitimate pregnancies resulting from changing attitudes toward sex;
- suicide due to increased emotional stress from family and scholastic pressures;
- the hippie movement due to emotional instability and rebellion against "The Establishment";
- indiscriminate drug use to rebel against authority and avoid daily monotony.

Our affluent society with its permissive parents is producing a generation of adolescents in turmoil.



"We are Carefully to Preserve That Life Which the Author of Nature has Given us, for it was no Idle Gift"[1]

"The atrocious crime of being a young man . . . I shall neither attempt to palliate nor deny; but content myself with wishing that I may be one of those whose follies may cease with youth, and not of that number who are ignorant in spite of experience."

So William Pitt answered Walpole's criticism in the House of Commons back in the 18th century.

Today we'd more likely hear:

"It's a gas, man; like you're the fuzz."

Translation: Youth has its follies of which each age must be tolerant. To be ignorant of youth's fads and fancies is to invite their scorn.

Today's adult population has a tendency to be ignorant of the true nature of adolescent fads manifested by bizarre dress and behavior. It is not true, for instance, that long hair, bare feet, and innovative dress are the habit of the drug abuser. The "Hippies" and "Flower Children" may or may not experiment with drugs.

It is a point to be remembered by officials and educators concerned with the drug abuse problem. We cannot assume that drug abuse occurs wherever and whenever we see the manifestation of youthful follies. We must make it our business to understand the mercurial nuances of fads and fancies so we can sort out the innocent from the hazardous; so we can be tolerant of the former and protective about the latter.

1. Harvey W. Wiley, from his commencement address, "Life and the Coming Time", Hanover College, 1867. Reprinted from *FDA Papers*, July-August, 1967.

HIPPIE TALK

by PATRICIA CHAPMAN

"Like dig it man. I'm doing speed and it's putting me through heavy changes. Do you mind if I rap to you?"

"No, man, just do your thing. Last week, I tripped and I was spaced out for three days. Wow, like this whole week has been out of sight."

Double-talk? Hardly. That's love talk—a language spawned in the growing underground of hippiedom in the United States. But more than that, this language of the long hairs is fast becoming the language of the young.

Hippie talk traces its origins to the Negro ghetto, to the beat generation, to jazz and rock music circles, to Psychedelician Dr. Timothy Leary, and to the Indian mystics.

Like slang, it's verbal shorthand with a vocabulary composed not only of new words but of old words with new meanings.

Most of the new words and expressions have to do with drugs. There are almost a dozen words for marijuana alone, the favored drug in hippiedom, and a score more for other drugs and the drug-induced state. Indian words are now coming into common usage as hippies switch their allegiance from Dr. Leary to Indian yogis.

And, interestingly enough, there are no words for alcohol or alcoholic inebriation. High to the hippies always means drug intoxication; so do words like "stoned" and "bombed." Few, too, are words for sex.

"We're not hung up on sex, as you people are," explains one hippie, "so we don't need all your dirty words." And hate? It doesn't exist for everlovin' hippies—or at least they would like you to believe it doesn't.

"Ours is a feeling language," says an underground newspaper editor. "It's also extremely picturesque. Take our word 'up tight.' Isn't that a lot more descriptive than 'tense'? You can just feel the knot in your stomach. It's a lot like Chinese, too, where the picture of a sun may mean warm, burning; one symbol or word can mean many things."

And the word "hippie"? It, like the word "teeny-bopper," which is used for the Brownies of the hippie movement, is strictly from Squaresville. Scoffs a hippie: "It was made up by a San Francisco writer, the same guy who coined the word beatnik. Strictly straight."

You can get it all straight in the following examples.

Reprinted from PARADE, November 5, 1967, with permission.

Acid—Psychedelic drug, (such) as LSD.

A Head—The user of acid.

At—(1) Where the action is, as "Haight-Ashbury is where it's at";
(2) To come to, to arrive, as "This is where I'm at."

Babe, Cat, Man—A person.

Bag—(1) Aptitude, specialty, as "Teaching is his bag"; (2) Consuming interest; (3) State of being, as "That's my whole bag"; (4) Obsessive interest with neurotic implications (see Hangup).

Blow Your Mind—(1) To have an overwhelming revelation, as "That music is a groove, it's blowing my mind"; (2) To go out of your mind with drugs.

Boo Hoo—Priest in the hippie Neo-American Church.

Box—Guitar.

Bread—Money.

Burned—Refers to purchase of bad drugs.

Busted—(1) Arrested; (2) To be found out by a person in authority, such as parents.

Carrying, Holding—To possess drugs, as "He's carrying."

Changes—Shifts in emotions, feelings, usually while under drugs. Also Heavy Changes.

Chippie—One who experiments with hard drugs.

Coke—Cocaine.

Cool—(1) User of drugs, as "He's cool."

Cop, Cop Out—(1) To get out, fail a responsibility, as "He's copped out"; (2) To obtain, purchase, as "He copped a joint."

Crash, Nod, Fall Out—To sleep, collapse from exhaustion, usually while in a drug-induced state.

Doing—(1) To take, as "I'm doing

FROM ACID TO ZAP

acid"; (2) To do, as "Do your thing."

Dig—(1) To understand, comprehend, as "I'm shooting, dig?"; (2) To like, as "He digs music"; (3) Exclamation meaning listen, hey, as "Like dig, man."

Down—(1) Discouraging, depressing, as "That's a down thing to say"; (2) Dejected, sad, as "I feel down"; (3) Coming out of a drug-induced state. Also Bring Down. Downs, depressants.

Drop Out—(1) To withdraw from society, to abandon certain social mores; (2) Ultimate state achieved during psychedelic experience. Also, dropping out; dropped out; dropout, the person who drops out.

Flip—(1) Metaphor for mental or emotional cartwheel induced by a stimulant such as dexedrine; (2) State of withdrawal induced by external stimulant such as noise, as "I'm flipping out." See Freak Out.

Flower—Hippie instrument of self-defense.

Freak, Freak Out—(1) To lose basis in reality through psychedelic drugs; (2) A bad drug experience.

Fed, Narc, Narco—Federal narcotics agent.

Get Into Something—To get involved in something.

Goof On, Put On, Jack Up, Hype—To laugh at, make fun of a person, as "He's goofing at you"; (2) To mislead.

Groove—(1) To concentrate, to observe intensely with enjoyment, as "He's grooving on the sea"; (2) To like, to enjoy; (3) A great thing, as "What a groove." Also, grooving, indicating achieving positive rapport.

Guide—(1) Person who offers guidance, support during psychedelic experience; (2) Also used in large sense to indicate a guru.

Guru—Rabbi, spiritual leader, teacher. *Orig. Indian.*

Hangup—(1) Neurosis, continuing problem, as "He has a mother hangup"; (2) Obession, as "Art is his hangup"; (3) To disappoint, to fail a person, as "Don't hang me up"; (4) To love, as "I'm hung up on her."

H, Horse, Skag—Heroin.

Hash—Indian or N. African hashish.

Head—(1) Person who takes drugs regularly; (2) Reference to emotional state of mind, feeling, as "That's his head." See A Head.

Head Shop—Drugstore.

High—(1) Elevated, euphoric state while under influence of drugs; (2) Used to refer to the drug experience, as in "Good high."

Ice Cream Habit—Refers to a person who is on and off user of drugs.

In—Being involved, a Be-In, Love-In.

Mantra—Indian chant.

Mandala—Indian design.

Old Lady—The woman in a man's life.

Om—Universal mind, universal being. *Orig. Indian.*

Out of Sight—(1) Incredible, amazing; (2) Really good, as "This scene is out of sight."

Out of It—(1) Not in touch, removed; (2) State of disconnectedness while under drugs.

Pad—Residence.

Pot—Marijuana. Other terms include: Acapulco Gold for Mexican marijuana; Bhang, African marijuana; Boo; Joint, the marijuana cigarette; Poke, a puff of marijuana cigarette; Kief, Moroccan marijuana; Grass; Mary Jane, anglicized name for marijuana; Panama Red; Reefer, cigarette; Roach, butt of cigarette.

Pudding—Godhead, cosmic mind, as "He's into the pudding."

Rap—(1) To talk; (2) To talk with rapport while in state induced by drug stimulant.

Scene—Place, environment.

Score—To purchase drugs.

Split—To leave.

Stash—Secret supply of drugs.

Spaced Out—In a daze, usually in reference to the day after a psychedelic trip.

Speed—Methedrine.

Scoff—To eat.

Straight—(1) Expression used to refer to the status quo, as "The straight world"; (2) Any non-user of drugs.

Thing—(1) That which involves a person, a specialty, as "Music is his thing"; (2) Achieving rapport.

Trip—Experience while under effects of psychedelic drugs.

Turn On—To excite, as "He turns me on"; (2) Act of Taking drugs.

Tune In—(1) To tune, focus during psychedelic experience; (2) State of inner watchfulness after the experience.

Underground—The hippie movement; also used to refer to hippie movies, plays, clubs, etc.

Up—(1) High on drugs; (2) Tensions. Also Up Tight, state of extreme anxiety; Ups, stimulants.

U.F.O.—Unidentified Flying Object, usually seen during psychedelic experience.

Zap—Exclamation.

Drug Addiction and Drug Abuse—

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The use of intoxicating and addicting drugs reaches far back in the history of mankind—as far back as written records. The opium plant was known to the Sumerians as joy-plant by 3000 B.C.[1] Homer has Odysseus tell about the fruit from the lotus tree, the Libyan plant Jejuba,[3] which lets his friends forget about their past and want to stay in the land of the lotus-eaters. The drinking of soma was the central rite of the *Rig-Veda* hymns of the old Indo-Aryans (ca 1500 B.C.)[4] and important as Haoma for the Iranian Avesta;[5] it is the intoxicating juice of Asclepias acida.[6]

A Synopsis

Beer was known in Mesopotamia in far pre-historical time, about 6000 B.C.; in Egypt it was used as a mortuary offering about 2800 B.C., and later was described as a gift of the god Osiris.[7] Noah planted the vineyard and became intoxicated by wine[8]—not better than god Indra by his soma.
Mead, an alcoholic beverage made from honey, was known to the ancient peoples of the North: the Celts, the Germanic tribes, the Slavs.[9]
The hallucinogenics peyote (mescaline) and psilocybin[10] were used by the North American Indians for religious purposes just as muscarine was used by some Siberian tribes and by the Scandinavian Berserkers—hence their proverbial fury.[11]



The use of most of the aforementioned drugs was interwoven with mythology. The intoxication was sanctioned and restricted to the religious ritual. It magically lifted the faithful over the boundaries of time, space and individuality and let him forget the limitations of reality. Thus they were considered a gift of the gods—of those ancient guardians of regression.

Is it then an accident that the whole area of these drugs still is shrouded in mystery and mythology?

There are few areas in medicine where mythology is still so rampant as in the area of drug abuse. Unfortunately, also, the boundaries between myths and scientific facts are not drawn sharply since scientific investigations are still insufficient and more knowledge is sorely needed.

Definition

"Drug Abuse" is the broader term, encompassing addiction, and refers "to the use, usually by self-administration, of any drug in a manner that deviates from the approved medical or social patterns within a given culture."[12]

There are three cardinal and obligatory symptoms of *drug addiction* proper. ■ The person feels "that the effects produced by the drug . . . are necessary to maintain an optimal state of well-being."[13] This *psychological dependence* or *habituation* may vary in intensity from a mild desire to a craving or *compulsion* to use the drug.

■ *"Tolerance* has developed when, after repeated administration, a given dose of a drug produces a decreasing effect or, conversely, when increasingly larger doses must be administered to obtain the effects observed with the original dose."[14]

■ In *physical dependence* it becomes necessary to keep administering the drug in order to prevent the appearance of the *withdrawal or abstinence* syndrome, which is characteristic and stereotyped for the particular drug.

A few words about these three criteria. The *psychological dependence,* often of compulsive dimensions, brings about the typical drug-seeking behavior, observed not only in human beings, but in animals as well. It originates, of course, in the feeling that one is not satisfied with what one has—for whatever reason. As long as we have only this psychological dependency, we have only abuse, not addiction, eg, in cases of dependency on aspirin, coffee, or LSD which are non-addicting drugs, or in the early phases of the use of truly addicting substances.

The next point is *tolerance.* Practically, this means two things: If the heroin addict wants to achieve a feeling of "being high," he has to shoot more and more of the drug. Another aspect of the same phenomenon of tolerance is that the addicted person tolerates, ie, can take enormous amounts of the drug, amounts which would kill a non-addicted person. This, then, explains why many addicts die from an overdose right after their release from jail. They start out with the same dose as they had needed before imprisonment and withdrawal—and now, of course, are not accustomed to any more, in other words, they have lost their tolerance. Their tolerance level may be fantastic. Some addicts may go as high as 3-4 gm of morphine or heroin a day; and the amounts of alcohol a hardened drinker (an alcohol addict) can tolerate without manifest signs of intoxication are proverbial and may serve Falstaffian boasting.

Now to *withdrawal;* the abstinence state is always very unpleasant, with some drugs life-threatening. Most of the symptoms of withdrawal can be halted almost immediately by intake of the particular drug, or of a pharmacologically similar one. By being pharmacologically similar, although chemically unrelated, different substances can substitute for each other to alleviate withdrawal: eg, methadone, a synthetic narcotic, removes the symptoms of withdrawal from opiates. It is due to this capacity, as well as to the fact that the subsequent withdrawal from methadone is much milder than from the opiates, that methadone is regularly used to withdraw patients from heroin or morphine. The same holds true for the substitution of barbiturates for alcohol: alcohol withdrawal can be treated by an artificial intoxication with barbiturates.[15]

Types of Drug Abuse

Almost all groups of drugs have one common property—besides their frequent abuse—which is the capacity of inducing acute states of intoxication which always interfere with social functioning and often, if severe enough, with life itself.

The first group consists of the *narcotics,* among them in particular morphine, heroin, dilaudid, and dicodid, all of them severely addicting. Codeine, though chemically closely related, is practically not addictive. In turn, the chemically entirely different substances demerol (pethidin, meperidine), and methadone (dolophine) are addictive, although less so than morphine. The direct effect

of all these narcotic drugs is that of alleviating pain and suffering. Historically it is interesting to note that up to 1800 the analgesic drug opium, the juice of the poppy capsules, was practically the only effective medication which the physician had at his disposal. But this analgesic effect is not the reason for their abuse. In many people who are predisposed to addiction, they cause a feeling of satisfaction and peacefulness, which has been called "a state of total drive satiation."[16] Hunger, anger, and sexual wishes are suppressed. Rado[17] distinguishes three effects: **"Narcotic drugs remove painful feelings, engender a pleasurable experience of specific quality, and produce a climactic sense of triumphant success."** He describes the first effect as narcotic riddance, the second as narcotic pleasure, and the third as narcotic intoxication or narcotic delusion of grandeur. This state of euphoria is accompanied by a moderate clouding of consciousness, by sleepiness and dreaminess.

As for the consequences—misconceptions in this area are vast and rampant even among physicians. A first error is to assume that addiction to narcotics causes, by itself, physical damage. It does not. To quote Kolb, one of the leading experts in the field of drug addiction: "I have seen addicts who have remained healthy despite their use of 3 to 40 grains of morphine daily for as long as 20 to 65 years."[18] This does not imply that there may be no long lasting or enduring physiologic changes. Rather, there are indications that following a state of addiction and withdrawal proper, some physiologic functions remain changed at least for a number of months, although this does not mean there is any physical disease. It appears that long lasting addiction may bring about enduring alteration of some physiologic functions; this may be a partial explanation for the continued psychologic craving for drugs years after withdrawal: For several months increased blood pressure, hyperthermia, mydriasis and increased respiratory rate can be found; still later, and again for a number of months, one observes decreased blood pressure, hypothermia, bradycardia, miosis and increased sensitivity of the respiratory center to CO_2.[19]

Much more important are the *indirect* consequences, due mainly to the illegal status of narcotics use. One is that this type of addiction is usually not compatible with full social *functioning*. After one shot, the patient may start to "nod" or to retreat into his pleasant dreams. If he is at the wheel of a car, this dreaminess conflicts with traffic safety. In his job he may neglect his duties to some degree. Yet even this is true only to a limited degree, mainly if the dose is not stabilized. **"The fact that many successful persons have been chronic addicts and were able to lead worthwhile, constructive lives is often forgotten in discussions of the addict's ability to work,"** writes Kolb. "Prior to the enactment of the Harrison Narcotic Law in 1914," Kolb continues, "there was no feeling among the general public that opiate addiction had appreciable adverse effects on work habits. At that time, addicts worked as regularly and as efficiently as any other group of people. The need for regulatory laws arose from the enslaving, difficult-to-cure physical dependence and not from addiction's economic meaning." He adds, however, that "it is a reasonable assumption that the lethargy produced by the drugs makes idlers out of some borderline cases."[20]

Another consequence is the *self-neglect;* the addict, especially if not on a stable dose, may not care as much about his physical needs—eating, cleanliness, care for his teeth, etc. A third and most dangerous group of consequences is directly due to the *illegality* of drug use. He can acquire drugs only at very high costs; he has to hunt them down, search for them for hours. The chasing after drugs in itself is a full-time profession, and precludes most steady work. Moreover, the addict has to steal and rob in order to finance his habit; or he may break into drug stores, doctors' offices and hospitals to get to the drugs themselves. In turn, he has to sell it to make up for the costs and thus becomes a pusher. If the addict is a girl, she uses prostitution to support the habit. Also, since the drug supply is so insufficient, hazardous, and the "bag" of unknown composition, the patient vacillates between successful intoxication and mild withdrawal—a state which is also not conducive to an ordinary social life. What this state of affairs means economically, you can assess: the 100,000 narcotics addicts of New York City alone steal at the value of $10 million a day.[21] In Baltimore it is estimated there are about 10,000 narcotics addicts (out of 60,000 illicit drug users), the fifth largest number in the nation.[22] You can calculate how much this costs.

A third misapprehension is that drug addicts favor violence and sexual crimes. This is very unlikely—the addicted person is too happy, the person during the withdrawal stage, too miser-

able. Norman Kerr wrote in the last century: "Opium sooths, alcohol maddens. The intoxicated by opium are serene, sedate, and lethargic."[23] Again Kolb states that **"it is conceivable that the number of violent crimes could be drastically reduced if all habitual criminals were addicts and would obtain sufficient morphine or heroin to keep sedated at all times. The effect of addiction on the behavior of the mentally abnormal criminal is to *inhibit* his impulse to crime."**[23] In observing a number of patients who were forced to live in abstinence, gradually, over the months, we saw them become more and more angry and tense, and perhaps after one to two years of enforced abstinence and exemplary behavior, commit a violent crime.

What are the *health hazards* induced by the illegal status of opiate use? The main risks are overdose, contamination, and infection. The dose, of course, is not known, nor can the addict himself accurately estimate his own tolerance. Again this is due in part to the various strengths of the "bags" he has had. Death from overdose is quite frequent. Overdose leads to respiratory arrest. The ensuing hypoxia causes softening and cystic defects of the globus pallidus and rapid death.[24] Since no one checks the content of the bags, the opiates may intentionally be adulterated with quinine or, even more dangerously, with digitalis. Infections, such as hepatitis, subacute bacterial endocarditis (with especially high mortality, since it is often caused by staphylococci)[25] and phlebitis, are common.

Withdrawal from opiates "cold turkey," ie, without substitution by methadone, is extremely unpleasant, but usually is not life threatening, except in cases of congestive heart failure or other serious disease.

Withdrawal can be observed even with addicted chick embryo cells and human cancer cells in tissue cultures. The chemical effects of addiction and withdrawal clearly occur on the cellular level and appear to interfere with the RNA synthesis in the ribosomes.[26] In the body, physiology morphine has a marked cholinesterase inhibiting property.[27]

A second group of drugs which are abused are the psychotomimetic or *psychedelic* substances. Intoxication with a wide variety of substances cause vivid hallucinations and dreamlike states. Such substances are LSD, Morning Glory Seed, Psilocybine, Mescaline, nutmeg, marihuana, DMT (dimethyltryptamine), STP, and airplane glue. Whereas the effect of the narcotics proper is a state of full harmony, the psychotomimetic substances induce a whirl of dreamlike images and strong emotions, accompanied or followed by a feeling of boundless union with the environment and often an experience of self-disintegration. They are not addicting in any physical sense, ie, one can withdraw them abruptly without ill effect. The effects of the intoxication vary.

LSD can cause severe threats to emotional stability. Persistent schizophrenia-like psychoses have been observed afterwards. Anxiety or rage during the intoxication in a few cases may be so strong that suicide or homicide occur. There have been several reports about damage to the genetic material of the cells.

Glue sniffing, the sniffing of solvents of plastic cement, what has been called "the ten-cent hallucinogen,"[28] and the repeated inhalation of ether and antifreeze, can have disastrous physical effects, chiefly upon the kidneys and the brain, and may be fatal.

Marihuana, however, appears to be harmless as such, except for the psychosocial consequences common to most drug use: escapism, self-neglect, penal prosecution, social disruptiveness by uncontrollable garrulousness and hilarity, interference with work and with traffic safety because of the lethargy during the acute intoxication. Although legally classified as narcotic, pharmacologically it belongs to the psychotomimetics.

Its direct effects were described by Yolles, the director of the National Institute of Mental Health: "It may induce a mild euphoria and lead to heightened suggestibility and a faulty perception, really an exaggerated notion of thinking more clearly, profoundly and creatively. In addition, it is known to cause reddening of the membranes of the eyes, rapid heart beat, muscular incoordination, unsteadiness, drowsiness, and distortion of time and space perception."[29] No physical damage is known, although it is not excluded that prolonged abuse may lead to chronic brain damage and to a psychotic syndrome. Like the opiates, the intoxication itself with marihuana (or Hashish, the resinous exudate of the hemp plant) does *not* cause violent behavior.

It is very dubious whether it is really the gate to opiate addiction, as propaganda says. It is known that about 20% of all college students have reported some experience with marihuana.[30] Obviously not many of them have passed this mythical gate and proceeded to opiates.

More reliable research is possible only now since the effective substance in marihuana, Tetrahydrocannabinol, has recently been synthesized in Israel and in this country.

What appears certain is that "marihuana is less physically dangerous and addictive than alcohol or cigarette smoking, both of which enjoy legal sanction."[31]

As Russell Baker recently wrote:[32] "All right, Dad, just tell me why it is, huh, that if pot is outlawed for being bad for you they don't outlaw cigarettes for being bad for you? Did you ever hear of pot causing cancer? Huh? Explain to me how that makes sense."

"Shut up."

Yolles in his testimony states that " 'scare' techniques are not only ineffectual, but are even detrimental to conveying needed information about the hazards of drug abuse."[33]

A third group consists of *barbiturates and glutethimide (Doriden).* They are truly addictive, just as the narcotics proper. The intoxication with barbiturates leads, as with most of the other substances, to sleepiness, and, with that, to impaired functioning: the speech is slurred, the gait atactic, staggering; the driving of a car is very hazardous. It is very important to know that withdrawal is highly dangerous. If barbiturates are withdrawn suddenly or too rapidly, epileptic seizures and delirium occur; these withdrawal symptoms lead in a high percentage to death, unless treated properly. What has been said about the barbiturates is valid also for meprobamate and chlordiazepoxide (Librium), although to a much lesser degree—there is psychological as well as physical dependence with epileptic seizures as withdrawal symptoms.

The fourth group, *amphetamines,* like benzedrine, ephedrine, eg, in nasal spray, or in the famous appetite-curbing pills (also the related drug preludin) are not strongly *physically* addicting; they can be withdrawn without much danger. Psychological dependence, however, is marked. The acute intoxication with this group is very dangerous. Violence, like assault and senseless murder, or the appearance of an acute toxic psychosis with ideas of persecution, uncontrollable agitation, restlessness, and severe fright is common.

Since the euphorizing effects of amphetamines and barbiturates are synergistic and cumulative, whereas the sedative effects of the barbiturates are cancelled out by the stimulative effects of the amphetamines, their combination in the form of "goof balls" or Dexamyl are particularly addictive.

Similar to those of the amphetamines are the effects of *cocaine,* the most potent antifatigue agent known. Hallucinations and persecutory delusions drive the cocaine addict to violence and destruction. The image of the "depraved dope fiend" of the past is that of the cocaine addict[34] and may be applied to some degree to the user of pep pills today—but not to the user of opiates. An acute overdose with cocaine can lead to seizures and to death from respiratory failure. It goes without saying that cocaine is not a narcotic at all, although legally it, too, is categorized as such. It is interesting to read how Freud introduced this drug into medical practice and what happened after his enthusiastic first reports.[35]

A sixth group of drugs often abused are the analgesics, especially the favorite combination containing *phenacetine* and caffeine, often with an hypnotic. This abuse is little known in this country, but very widespread in Europe (eg, 5,500 cases in Switzerland alone). Examples for this group are Empirin and Fiorinal. The typical sequence is: It is taken against tension headaches. As time goes on, the patient, usually a sensitive, conscientious person, discovers the calming and euphorizing effect and may take it in between the attacks of headaches. Then, he, or more frequently she (80% are women), has to take more and more, and may end up, like the watchmakers in Swiss factories, with pill-sandwiches. It is a true addiction, with tolerance and withdrawal symptoms, and leads to severe, often fatal, blood and kidney damage.[36]

Finally, there are the two commonly accepted poisons, alcohol and nicotine. *Alcohol* is not a harmless substance when taken for acute or chronic abuse. It is truly addictive. The acute intoxication leads, like one with barbiturates and opiates, to reduced alertness and to motor incoordination. There is little reason to doubt that **"50% of fatal accidents are caused by drinking drivers, many of whom are 'social drinkers' rather than alcoholics."**[37] Comparable to the amphetamines, alcohol in higher doses reduces the inhibitions against aggressive and sexual acting-out. Overdose with alcohol is as lethal as with most other intoxicating drugs. The term "beer death" was well known in the old German

student corporations. Chronic abuse, even without manifest drunkenness, gradually leads to a slow destruction mainly of the brain and liver cells. Abrupt withdrawal of alcohol is followed by delirium tremens and, sometimes, by epileptic seizures—both acutely life threatening. It can be safely stated that **"alcohol outranks all other dangerous drugs by a wide margin in its total damaging effect on millions of people and society in general. After all, alcoholism is our fourth largest public health problem."**[38]

Nicotine itself, although truly addictive, does not seem to have serious effects, although recent investigations indicate an increase of coronary sclerosis in smokers, due to the effect of this substance. Yet since smoking does not result in the absorption of nicotine alone, but of other potentially more dangerous substances, long-lasting abuse may lead to bronchial cancer and other serious diseases.

Only if we examine all these drugs not for their dangerousness, but simply for their addicting property, the opiates are leading. It takes only a few shots of heroin or morphine to evoke in many people, though not in all, the compulsive need to go on with the drug, to increase the dose and to avoid withdrawal symptoms. It is mainly this fact, and not any special danger, which explains the rigorous legal intervention against use of narcotics.

We may indeed wonder about the inherent philosophy and value system of a culture which condones the use of substances which unleash aggression, yet condemns with utter severity drugs which re-enforce passivity and dreaming.

The Laws

It has been said that "there is no such thing as public opinion; there is only public emotion."[39] The official attitude and the laws reflect this "public emotion" which in turn is whipped up by propaganda. Clichés steeped in bias are rampant; comparatively little research has been done to counter the contentions.

Particularly since World War II, the punitive approach to narcotics addiction left the severity of punishment for nearly all the other crimes, including murder, far behind. Since the Narcotic Control Act, the Boggs-Daniel Law of 1956, the minimum mandatory sentence for first offense is two years; the sentence for second offense may range between five and twenty years and for the third offense, between ten and forty years. Further, there is no parole or probation for second and third offense. An offender more than 18 years old who provides a person under 18 years with heroin may be imprisoned for life, or not less than ten years, or may even be executed. How this affects medical practice can be seen from Kolb's comment: **"Almost immediately after the Harrison Act became effective in 1915, there began widespread indictment and imprisonment of physicians for narcotic violations. . . . For the most part, the physicians were indicted for prescribing narcotics for patients whom they saw as having a desperate need for the drugs. . . . Williams has written that by 1938, 25,000 physicians were arraigned and 3,000 served penitentiary sentences on narcotic charges. . . ."**[40]

In 1966 the Congress approved legislation giving "Federal judges broad power to suspend criminal proceedings against narcotics addicts who show promise of cure"[41] and providing for civil commitment. The latter "involves confinement and treatment in an institution and under supervised aftercare in the community."[42]

Stringent measures against the distribution of amphetamines and barbiturates have been enacted 1965 (Drug Abuse Control Amendments); they consist mainly in the exact record keeping by pharmacists and dispensing physicians of all dispositions of the controlled drugs, and the keeping of these records available to FDA inspectors. The penalties in cases of transgression (peddling, giving to minors) are high, although less than with narcotics.[43]

The *British system* in regard to narcotics regulations is much more liberal and actually represents a partial legalization.

The distinctive feature of the British system is that narcotics may be administered "when the patient while capable of leading a useful and fairly normal life so long as he takes a certain non-progressive quantity, usually small, of the drug of addiction, ceases to be able to do so when the regular allowance is withdrawn."[44] **"The continued provision of supplies to patient addicts depends solely on the individual decision made by the medical practitioner professionally responsible for each case."**[45,46] There is no registration of addicts in Great Britain, as it is at times assumed.

These British rules are presently tightened, though not principally changed. The number of

prescribing physicians is to be restricted to those working in special "treatment centers" for addicts, since a small number of private physicians prescribed unreasonably large amounts of drugs which found their way to the illicit market.[47]

The results with the two systems are different. Officially it is claimed that the American punitive approach has reduced the number of addicts from 264,000 at the turn of the century[48] to 62,000 now[49]—but this concerns only the known addicts. It is assumed that the correct present number may be six to ten times higher.

Great Britain has now around 2,000 addicts being treated by physicians.[50] The number is rapidly growing, by about 20% during each of the last years, as compared with the official growth rate of 10% in the U.S.[51,52] Still, if we remember that England was "afflicted earlier and more seriously with opiate addiction,"[53] the success of the British measures seems remarkable especially if we consider their much more humane and scientific character and the absence of a large scale black market, as it exists in America. "The surplus was reasonably priced, undercutting any heroin that might be brought into Britain illicitly. The result is that the international traffic in heroin has remained virtually clear of these shores."[54]

Kolb goes so far to say: "If the English methods could be adopted here, our narcotic problem would be solved quickly,"[55] although one has to consider that the social problems contributing to addiction are here quite different from England so that it is doubtful whether an uncritical application of the British system would work.

Predisposition

Quite obviously there must exist a *psychological* predisposition for drug abuse. Practically everyone who is today an addict is, *a priori,* a disturbed individual: **". . . those who persist in the use of drugs and eventually become compulsive users of narcotics have personality disturbances that antedate their contact with the drug,"** writes Jaffe. "It is also felt that the emotional disturbance would have manifested itself even in the absence of drug use, and that the use of drugs may be an attempt to cope with this disturbance."[56]

Three general observations can be made: In general, people are predisposed to use that drug which in the long run increases their inherent weakness. The opiate, barbiturate and analgesic addict is basically passive-dependent, of a sucking kind of demandingness, with his aggressions turned mostly against himself. He is a rather weak, soft spoken, friendly personality. This attitude is increased by his addiction. The alcohol, amphetamine and cocaine addict is usually inclined to turn his aggressions outward, and to live out his sexual impulses in a "pseudo-masculine" fashion. Again, this increases in the course of abuse and addiction.

In Jaffe's words: **"Narcotic addicts are individuals in whom the chief sources of anxiety are related to pain, sexuality, and the expression of aggression. Opiates seem to suppress the *sources* of these anxieties, thus permitting the use of narcotics to make a passive adaptation to his true tensions. Alcohol and barbiturates, by contrast, reduce the inhibition of drives and often aggravate the basic conflicts."**[57]

Moreover, we observe that the severity of the underlying psychological disorder parallels the illegality, the social unacceptability of the particular drug use. A cigarette addict is, in general, less disturbed than a heroin addict.

All persons prone to drug abuse and drug addiction are unwilling to accept the limitations of reality and to tolerate frustration. The conflicts causing this attitude are not specific although they always seem to involve magical omnipotence and correspondingly radical feelings of helplessness and hopelessness.

Yet, there is no pathology typical for all addicts (or for all narcotics addicts alone). One finds all forms of psychopathy, of neurosis, and also some psychotics among them. Usually, they are bored people, dissatisfied with themselves and with society, often very markedly depressed and anxious. Their conscience is inconsistent—in some regards too harsh and rigid, in others indulgent. It is archaic and easily projected to the outside.

The reliability and honesty of these "junkies" is therefore poor. Partly, this is the consequence of their need to conceal their habit, partly due to their deep-seated attitude of not accepting limitations. As a matter of fact, most of them have had a criminal record already as youngsters, years before they even started taking drugs. As mentioned before, it may happen that a notorious criminal improves socially under the moderating influence of narcotics. Also severe chronic anxiety states and incapacitating depressions may improve once the person becomes addicted.

There have been very few attempts to describe the dynamics of narcotic addicts.

Rado's analysis has been mentioned before. He attributes the proneness to addiction to a presumably genetically rooted predisposition to retain an archaic "more powerful primordial, omnipotent-self than is the case with the vast majority of the members of society." Due to this predisposition "narcotic pleasure elicits a response of narcotic grandeur." It is this grandiose conception of the self which makes the craving for the drug uncontrollable.[58]

Very typical are omnipotence, grandiosity, and magical thinking, as M. Nyswander writes, they are revealed by conscious daydreams. **"Mistrust bordering on paranoid projections is frequently encountered. An inability to relate other than in a narcissistic fashion is best illustrated by the addict's frequent belief that he is so uniquely interesting that he should be paid by the treating psychiatrist."**[59]

In a later publication, however, she repudiates this view. Describing her methadone program, she states, "We have seen no sign of a fundamental psychological defect or of a pleasure-seeking personality."[60]

Martin Hoffman describes as most striking clinical finding in the psychoanalytic psychotherapy with drug addicts an "abysmally low self-esteem."[61] "The addict, without his drug, suffers from a 'tense depression' which is then relieved by a pharmacogenic elation. This pharmacogenic elation is characterized by two essential points: 1) It is brought about by the ego itself, at will, and therefore gives the addict an omnipotent sense of control over his mood. 2) It resembles and is patterned on what Rado called the 'alimentary orgasm' . . . if the addict is indeed fleeing a depressive state he needs a euphoric agent which will act as long as possible. Sexual intercourse is too brief a depression-free interval for him; thus he needs a long-acting euphoriant which he finds in opium"—acting long enough to gratify his wish for the "alimentary orgasm."[62] "When an unfortunate event occurs they tend to develop an immediate sense of depression, since they always attribute the event to their own basic unworthiness. If they are to defend against this feeling by a show of hostility, they must really do this with a vengeance. Therefore their hostility is of necessity quite strong. This frightens them, in many cases, and therefore they look for a good 'out.' Heroin provides the ideal answer, for it depresses the hostility and raises the crumpled self-esteem at the same time."[63]

What do we observe when narcotic addicts are forced with strict controls (urine control and parole, see below under treatment) to stay off their drugs?

Most frequently they are found to be very dependent, passive persons who want to be taken care of and gain attention in a very childlike and very self-centered fashion. If they don't get the admiration they feel entitled to, they become infuriated; they are not able to express this rage, but it manifests itself in depression and self-destruction instead.

■ Only a very few addicts stay off narcotics altogether; at least sporadically, drug use can be discovered; there are obvious correlations with times of inner and external tension bringing about these periods of decompensation. Sporadic drug use does not lead inexorably to drug addiction; most deviations remain singular.

■ The conflicts underlying these tensions are of some individual specificity, and cannot be reliably generalized. These conflicts are usually, although not always, of an archaic nature and consist of primitive wishes for omnipotence, total dependency, and passive gratification, what Murray called the *"narcissistic entitlement"*[64]; of feelings of deep despair, self-devaluation, and emptiness, if these desires are frustrated; and of subsequent reactions in the form of overwhelming rage, if these frustrations cannot be covered and denied.

In most of the cases observed in our program, insidious neurotic depressions as a consequence of prolonged and enforced abstinence, often with considerable irritability, and much boredom, restlessness, apathy; these states are suddenly and magically interrupted if the patient resorts to intake of the drug.

■ When the narcotics exit is closed, other forms of basically pathologic *substitute-gratification* and *substitute denial* are sought. Most frequently the patients resort to excessive use of alcohol; in fact, the easier it is for a patient to switch to another type of addicting substance, particularly alcohol, the more successfully he copes with the problem of opiate-addiction. Other substitute gratifications used in addition to alcohol are marihuana, barbiturates, promiscuous sexuality, or excessive food intake.

■ In several patients, the aggressivity, based mainly on *intense oral rage,* tends to become over-

whelming and threatening once the drug use is suppressed. Many patients have great difficulty containing their potentially dangerous explosiveness and violence. This is of particular danger in those patients who succeed in replacing opiates with alcohol, pep pills, or cocaine-substances not picked up with the routine urine test. The easier the transition to alcohol, and the more successful the abstinence from narcotics, the more prone to violence the patient tends to be (this is a rule of thumb which has exceptions).

■ More frequently, however, *depressive episodes* occur which become so serious, that in some an antidepressant has to be given—usually, though, without convincing results.

In addition to the psychological predisposition, there are *social* factors. Addiction to heroin is prevalent in the slums. A lot has been said about the sinister role the "pushers" play. It largely belongs in the realm of mythology. **"Contrary to widely held beliefs," writes Jaffe, "the 'peddler' or 'pusher' does not play a major role in enticing nonusers to try either opiates or marihuana.... The pusher feels safe only when selling to a known addict. Furthermore, solicitation is unnecessary. Illicit drug traffic is a seller's market."**[65] Social misery and early seduction, usually by slightly older playmates (the "dominant influence of deviant peer-group associations,"[66] are the main precipitating causes of addiction in the slum dwellers. Similarly, M. Partridge writes, "the best way to become an addict is to know one. Addiction is almost a contagious disease."[67]

Quite typically, addicts' families are uprooted, have broken with their traditions of rural life or lost their spiritual background. Thus, it was observed that the same most blighted areas in Chicago, which showed the highest prevalence of narcotics addiction in the thirties, still showed the highest incidence in the fifties. Yet, 20 years before it was inhabited by immigrants from Eastern Europe, and now by Negroes from the deep South.

"The old and new residents of these areas of high drug use had one thing in common: social and economic deprivation."[68]

Most addicts are unskilled laborers, coming from broken homes.

Another kind of predisposition is that of persons in medical professions; disturbed individuals in these professions have narcotics easily available. Wherever these social predispositions exist, they have to join up with some psychological disturbances to lead to drug addiction.

In contrast, patients treated with opiates during physical illness may become pharmacologically addicted, but most of them do not show any propensity after withdrawal to return to drug use. They do not develop psychological dependency. The same holds true for melancholics who, in the past, at a time when other antidepressants were not yet known, were often treated with an opium solution.

A third type of predisposition, a *cultural* one, is of an entirely different nature and not only relevant as motivation for narcotics addiction, but for other types of drug abuse as well, especially for LSD, marihuana, amphetamines and barbiturates. Yolles states, "We live in a drug-oriented culture. . . . I think that if we are to get to the root of this problem of drug abuse, we must be prepared to investigate and identify the underlying problems which lead people to distort or ward off reality with drugs."[69] He points then to the "alienation" of the youngsters from the older generation and the radical doubt they have for the "relevance of major societal values and institutions." He quotes Freedman and Brotman: "Some youngsters who feel helpless to accommodate to or change an unacceptable world, consciously choose to alter their own. . . . Their most frequent statement is that life is a 'drag.' It lacks meaning for there is no engagement; the future is unknown but certainly horrible. Since you cannot alter the world or determine the direction in which it will go, you must alter your state of consciousness and perception, ie, see the world and experience the world through a 'high'."[69]

In short, drugs are an escape from severe emotional and social problems, though a spurious and detrimental one. It is clear that with withdrawal and enforced abstinence the problem of treatment only begins. To use a catchy phrase: Drug addiction is a symptom of the disease, it is not the disease itself.

Methods of Treatment

The first step is withdrawal which always should be carried out in a hospital and is relatively easy. It may be a matter of one to two weeks. Opiates are withdrawn with methadone, alcohol with barbiturates. Not truly, or not strongly addictive drugs such as LSD, amphetamines, and cocaine can be stopped abruptly without ill-effect.

The long-term treatment of abuse and addiction is very difficult and complex and is designed not only to prevent the patient from returning to his drug use and to other types of compulsive behavior, but should also help him to resolve some of the underlying psychological, social and culture induced problems. In all this, it is clear that ". . . abstinence is inadequate as an exclusive goal of treatment but must be only one portion of a total program of social rehabilitation."[70]

■ *Psychotherapy:* A solution of the underlying character difficulties appears very difficult. Unfortunately, very little has been done in the form of psychoanalysis or psychoanalytically oriented psychotherapy. The focus of insight oriented psychotherapy is on clarification of the main denied consecutive elements: 1) the grandiose self image and the general demandingness and unwillingness to stand frustration; 2) the low self-esteem and sense of emptiness; 3) the resentment and rage. Clarification of these elements—although not reaching really unconscious levels[71]—can be quite helpful.

The psychotherapeutic techniques used most frequently, however, fall in the category of "repressive inspirational" methods,[72] where the defenses are increased and where group solidarity and dependence upon an authority figure are fostered and used as the main therapeutic agent. Their long-range effects are obviously highly dubious. Examples are supportive individual or group therapy or counseling by social workers, nurses, prison personnel, clergymen, or physicians. Generally it can be stated that if psychotherapy or psychoanalysis is to have a chance, it has to be coupled with a safeguard against returning to drugs—in the form of verification of abstinence.

■ *Supervision:* In the last ten years it has become more and more obvious that one essential element of treatment is compulsory supervision after discharge from prison or hospital. Without any systematic follow-up therapy, the success rate is minimal. It was observed that more than 90% of patients, discharged from the Federal Hospital in Lexington, Kentucky, (during the period 1952-55) to the New York City area, got readdicted, most of them within the first six months.[73] The prognosis after jail sentence is not any better than after prolonged hospitalization.[74]

In contrast, when the patients were put on parole after release, 67% stayed abstinent in the community for a year or more.[74] Similarly, **"92% of California physician addicts, who were subjected to a long and strict period of probation, were known to be abstinent for at least two years,"**[75] whereas the relapse rate after voluntary hospitalization is over 90%. Vaillant writes that 90% of his parole successes had relapsed after other forms of treatment, 80% after hospitalization, and 60% after long or short imprisonment. The essential difference lies in the close supervision by the parole officer, with his close affiliation with the police. The parole officer is thus both an authority figure and an active helper. "At the same time, the parole officer, often with a degree in social work, works to help and not to punish. However, unlike the doctor, the parole officer can often find his "patient" a job; and unlike the judge if his "defendant" relapses to drugs while on the job, he can enforce institutionalization without a lengthy trial."[76]

That compulsory supervision is effective makes sense also from a psychodynamic point of view. Patients with the acting out of delinquent tendencies of many kinds have a "minimal internalization and inadequate superego control" and often demand external controls.[77] The question is how this substitute superego can be made more enduring and gradually internalized. We do not know how. A grave danger inherent in these supervisory manipulations should not be overlooked. The risk is that these external controls take on the same archaicly punitive character as the patient's own fears, and thus in the long run intensify the underlying conflicts. I refer in particular to punitive measures which lower even more the already very vulnerable and shaky self-esteem. In contrast, measures which heighten self-reliance and responsibility (and certainly supervision can be used for this purpose too) are much more helpful and appropriate than restrictive authoritarian interventions. This point cannot be emphasized enough.

How can this supervision be made more reliable?

■ *Urine Control:* If the parole method is combined with a stringent urine control with the help of thin-layer chromatography, compulsory supervision is much tighter. This is the method of the Baltimore Narcotics Clinic. A strict system is instituted. Every patient has to come in every evening to give his urine under surveillance by an attendant. If he stays free of drugs, he gradually can earn three evenings a week off—not more. If he deviates in any way, he loses his days off;

if he shows a certain number of positive specimens or absences, he is returned to the prison. He may be readmitted to the program after several months. Group therapy by psychiatrists and counseling by parole officers are other aspects of this system. The success rate in this very strict parole program is about 20%; 20% more abscond. The rest are back in jail.[78] My personal impressions of the psychological implications of such a program have been already mentioned above (under "Psychological Disposition") Certainly, the cautionary remark voiced in the section about "Supervision" applies to any program using urine controls as well.

■ *Narcotic Antagonists:* The treatment with narcotic antagonists seems to be very promising. Nalorphine, which has to be injected, has been in use for about ten years,[79,80] cyclazocine, an oral blocking agent, for about two years[80,81]; and a very new and apparently excellent drug, naloxone, has just been reported.[82] All three effectively block most of the euphorizing effects of narcotics; but the third one, naloxone,[82] seems far superior over the other two since it does not cause any undesirable side effects, whereas nalorphine and cyclazocine possess marked sedative and even psychotomimetic qualities. Also, withdrawal from naloxone does not bring about any abstinence symptoms—again in contrast to the other two. I have not yet read or heard about any treatment results with naloxone, but the preliminary experiences with the other oral antagonist, cyclazocine, are very promising.

■ *Methadone:* The results in the relatively careful methadone research study in New York, undertaken by Dole and Nyswander, are very impressive. Eighty percent of the several hundred patients treated are fully resocialized; they work, study and remain free of opiates.[83,84] There is no impediment to psychomotor functioning and to intelligence once the patient is on a stable dose.

But let us not fool ourselves. This is not a medical breakthrough, this is a partial legalization. Methadone is a narcotic in every sense. The patient is artificially addicted to very high doses of the drug; he has reached the plateau of tolerance where further increase of dosage or any other narcotic does not bring about any subjective effect anymore. Scientifically, it is not permissible to call it a "narcotic blocking agent" or a "narcotic antagonist."

Nonetheless, methadone has distinct advantages over heroin or morphine as a maintenance narcotic: Since pharmacologically it has a much flatter curve of effectiveness, it has to be given only twice a day and not four to six times; the onset of the euphorizing effect is gradual—in contrast to the sudden flash with heroin—and it is considerably weaker than with heroin. It lasts for 8-12 hours. Moreover, it is given orally, not by injection. If Rado's differentiation is used, methadone achieves the first two effects of a narcotic: the removal of painful feelings, and the engendering of a pleasurable experience, but does not impart the same sense of triumph and grandeur as the heroin.[85] These advantages make it, however, less liked by many addicts who prefer the orgastic experience of heroin over the milder effect of methadone.

Due to the stable effect of methadone, a person addicted to it can be fully socialized. This is a more difficult process for the heroin addict who continually vacillates between mild intoxication (right after the shot) and mild withdrawal (in the steep decline of its effect). In regard to this pharmacological property, morphine appears to be in the middle between heroin and methadone.

■ *Synanon:* This is a voluntary program in which group solidarity, group pressure and massive intervention in the form of shaming are the main treatment factors. Quite obviously this method gratifies the archaic dependency needs and the equally primitive demands of the conscience of the typical addict, and successfully replaces one dependency with another.[86] In Daytop Village (Staten Island, New York), an intensive, prolonged program combating narcissistic withdrawal by encouraging pride and group cooperation is being employed.[87]

■ *The Combination of Methods:* The best course of treatment seems to be a combined approach: 1) to start out with urine control and psychotherapy alone; 2) if this fails, to put the patient on naloxone or cyclazocine; 3) if this fails, to hospitalize the patient until safely free of drugs and readmit him to the program; 4) the hard-core recidivists could be put on methadone under strict supervision. The whole program requires constant and systematic built-in controls —not so much for research purposes but in order to keep the program as free of deviation and deception as possible. Only so is psychotherapy feasible; otherwise the secret acting out prevents any working through of resistance.

In this connection, it is of particular relevance to prevent not only the return to drugs, but the use of any kind of destructive compulsive behavior. I have observed many times patients who were able to refrain from drug use went over to drinking or to promiscuous sexual acting out. Obviously, the substitute of one compulsion by another is no real improvement even if the records show abstinence from narcotics.

The long-term treatment of other forms of drug abuse and alcoholism runs roughly parallel narcotics addiction, although even less is known about a systematic treatment approach. A combination of close supervision with psychotherapy again seems desirable.

■ *Long Range Plans:* When we look back to the misconceptions mentioned we see that many of today's laws reflect myths, not scientific fact. A partial legalization would be vastly better than the present system, eg, in the form it takes in Great Britain, or in the present experiments with methadone in this country. This would stand in accord with the philosophy expressed by Governor Meyner of New Jersey in 1956, when he vetoed a narcotic bill: "We do not sacrifice individuals for the common good, rather we find the common good in doing justice to the individual."[88]

In addition, the public should be factually and objectively informed. Especially in the schools, systematic teaching should be done—starting with the 11-13 age group. Youngsters who appear predisposed ought to receive adequate preventive treatment. Scare techniques which provide addiction with unsalubrious thrill and glamour are to be avoided.

The main goal is to substitute scientific fact for mythology. Only if we—the public—find the way from dependency on fantasies to the acceptance of sober reality are we able to help the drug abuser to go the same way.

A complete list of references will be supplied upon request.



The Drug Problem

"It has been ..... 's experience, and many others, including my own, that the mind-drugs, the hallucinogens, do very interesting and wonderful things and greatly open the mind to the creative processes."

The wish for instant paradise is as old as man himself. For ages, people have searched for artificial means to improve their condition, and drugs have played an important role in this quest.

Among Young People*

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The current publicity attending the unauthorized use of drugs by young people has convinced the general public that drug taking is a new problem. It is not. For thousands of years, alcohol, peyote, marihuana, hashish, opium and other substances which produce similar effects (such as laughing gas [nitrous oxide], ether and glue solvents) have been used to alter human consciousness and distort the ordinary sense of, and responses to, reality. What *is* new, however, is the high incidence of young people participating in "the drug scene" and the extent of acceptance or encouragement of it by influential members of the literary and academic worlds.

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Of all the hallucinogenic agents, LSD (lysergic acid diethylamide) and marihuana (cannabis) are at present the most widely used. Less extensive use is made of mescaline, bufotenine, psilocybin and demethyltryptamine.

The pharmacological qualities of LSD are discussed in a recent article by the Committee on Alcohol and Drug Dependence of the AMA Council on Mental Health.[1] As yet, research has not established LSD as an effective treatment for any disorder. Such research, however, is gravely handicapped by emotional reactions toward the drug, engendered by its irresponsible and illicit use.

The chief objection to the use of LSD arises from the growing body of evidence that it produces irreversible changes in the life style and personality of those who use it. Physiological changes are suggested in Cohen's work on chromosomal disruption.[2]

Psychological changes usually include impairment of the subject's ability to make realistic judgments. An individual who is under the influence of LSD can ignore facts previously held to be valid and construct new beliefs, no matter how irrational. Such forms of thinking bear much similarity to psychosis. A person may feel that he has powers which he did not previously have, or that certain laws of the environment (such as vulnerability) are not operative in his case. For example, feeling omnipotent, he believes that he can jump out of a window without being hurt. Wishful thinking becomes prominent. Preoccupation with isolated aspects of sensory experiences may replace all other sensations. Most characteristic of all is the abandoning of long-term patterns of striving, which Freedman and Powelson[3] describe as follows:

> "LSD enthusiasts talk of religious conversions, the awakening of artistic creativity, the reconciliation of opposites. The main change to be observed in such individuals, however, is that they have stopped doing anything. The aspiring painter talks of the heightening of his aesthetic sensibilities and skills, but he has stopped painting. The graduate student who withdrew from writing his dissertation in philosophy talks of the wondrous philosophical theories he has evolved. But nothing is written. It seems that the world of fantasy has become far more compelling than external things. Indeed, fantasy is substituted for reality."

One enthusiastic user of LSD and marihuana says, "It has been ....."s experience, and many others, including my own, that the mind-drugs, the hallucinogens, do very interesting and wonderful things and greatly open the mind to the creative processes." To an observer he appears to have abandoned the usual efforts to be clean, neat and presentable; he has failed in college, has no job (and doesn't want one), yet insists that he has achieved happiness. Like many other users of the hallucinogenic drugs, he insists that physicians who take care of those who become disturbed or psychotic know nothing about the drugs, refuse to see their good qualities, and are in no position to judge them because they have not taken them themselves. Clinical reports of persons involved in acute and chronic psychoses, suicide, or even murder are discounted by the more ardent advocates of drug usage as being so few in number as to be insignificant.

In the past, most users of illegal drugs had deprived socio-economic backgrounds and poor social and educational records, a tendency to criminal behavior, and preferred narcotics to other drugs. *In general, the new users come from the middle class, have had good educational experiences, and often are involved in intellectual or creative pursuits.* When drug use changes their attitude and capacity for judgment, the differences are much more noticeable than they are in the more deprived groups.

The evidence of harmful effects of marihuana is less clear than that of LSD. In fact, many people insist that its use has no disadvantages other than being illegal, and some groups are campaigning vigorously for legalization of marihuana. A comprehensive presentation of the proponents' arguments appears in Ginsberg's[4] *Atlantic Monthly* article "The Great Marijuana Hoax."

On the other hand, there are those who maintain that marihuana's dangers go beyond the legal ones. As with the drug's advocates, its opponents' points of view constitute a spectrum, with some objecting on moral grounds, some on the basis of its psychological and physiological effects, and some who do not oppose use of marihuana *per se* but interpret it as a sign of young people's personal and societal difficulties and an unconscious call for help.

Keeler[5] has reported 11 instances of adverse reactions to marihuana. Some of them were of psychotic proportions and included panic, fear, depersonalization, gross confusion and disorien-

tation, depression, and paranoid reactions. Four subjects became schizophrenic (with thinking disorders and inappropriate affect) after extensive use of marihuana, amphetamines and LSD. Keeler is of the opinion that marihuana can produce psychotic disorders of a serious degree and that its use can initiate destructive changes in life style. When there are differences of opinion on this latter point, the "patient" approves the change but most other persons do not.

My experience, and that of my colleagues at the Harvard University Health Services, support the contention that the use of marihuana does indeed entail risk. In fact, we find it to be harmful in many ways and to lack counterbalancing beneficial effects. Many students continue to think it is beneficial even while their grades go down and while other signs of decrease in responsible and effective behavior become apparent.

Some Characteristic Complications

A few characteristic complications of marihuana usage will serve to illustrate our concern:

A 21-year-old woman was involved in a conflict with her mother regarding choice of serious dating partners, following which she renounced her religion, drank to excess, and became promiscuous. When she became fearful of the effects of drinking she began smoking marihuana regularly. She then became depressed. To combat her depression she used more and more marihuana and, on one occasion, after smoking an unusual amount, slashed her wrists and was admitted to a hospital. Under psychotherapy she improved, stopped using drugs, and resumed effective academic work.

A 19-year-old man with high moral standards became depressed, used marihuana to combat an acute depressive episode, experienced "black despair," and then obtained sedative pills from a friend which he took in an attempt at suicide. After admission to a hospital and subsequent treatment for his depression, he improved and has resumed his studies.

A 20-year-old woman with a long history of emotional conflict became socially irresponsible, intermittently depressed and occasionally overactive and irritable. She tried marihuana to combat her symptoms but found that it was not giving her the "kick" she had sought. On the advice of friends, she began taking LSD with the hope that it would enable her to gain insight and become more aware of herself. Her potentially disastrous behavior continued and psychotherapy was refused.

A 19-year-old man with dirty clothes, unkempt hair and beard, in conflict with his parents, hopeless about society, has been taking benzedrine, dexedrine, marihuana and LSD, "to find out about himself." He views those who encourage him to avoid drugs as part of the hostile establishment who are infringing on his rights. His use of drugs serves as a barrier against development of the kind of satisfying interpersonal relations he desires as well as an obstacle to psychotherapy.

A senior premedical student with an excellent academic record, already admitted to a medical school, suddenly began to do failing work in one course. He said his energy had been diverted into trying to stop using marihuana, which he had begun using extensively during his senior year. When faced with the necessity of studying he found it easier to "take pot." Under its influence he was convinced that studying for examinations was not as important as other things. He wanted help, stating explicitly that he considered the use of marihuana harmful because it encouraged him as well as his friends who used it to "evade reality and pursue illusory goals".

Another student denied that his extensive use of marihuana adversely affected his academic performance, but said that while under its influence he lost both the desire and ability to study. At the end of the semester his grades dropped precipitously. He refused psychiatric help, saying that although he knew he had an emotional problem, drugs had nothing to do with his academic difficulties. Whether or not he is right cannot be proven at present, nor is it relevant, since he is in trouble and does need some kind of help.

These cases illustrate some of the issues involved in the great marihuana debate. In no instance did marihuana cause the original conflict. On the other hand, it contributed nothing positive and probably added to the problems each person faced; indeed, it may have delayed or prevented effective approaches to the solution of their conflicts.

In one sense, it is misleading to talk about "the drug problem" as if it were an isolated phenomenon for, in fact, it is only one aspect of young people's position in contemporary society. If drug taking were not related to current social conditions and individuals' reactions to them, it would be much easier to deal with. But the issues are complex; that is, drug taking *means* something.

Fashionable Aspect

Undoubtedly, fashion has something to do with drug use. In some circles, and particularly among the young, experience with drugs has become a kind of social currency, a source of status and esteem. It is possible, therefore, that if drug taking were no longer condoned by most young people, the users, deprived of the gratification of peer approval, would turn to other (ideally more constructive) methods of dealing with their personal problems.

But if there were not more fundamental factors at work, drug taking would go the way of goldfish swallowing and telephone booth cramming. The fact that drug taking is illegal reveals its function as a form of rebellion and protest—and it is tempting to write it off as such—that is, as a typical "phase" of youth which should be ignored because its passing is inevitable, or treated with a get-tough policy. It would be wrongheaded, however, to do so; *young people's rebellion is meaningful to them, and constitutes both a response to their situation and a way of dealing with it.* Furthermore, their judgments often are more valid than older generations care to admit.

On a personal level, young people tend to suffer intense feelings of isolation and vulnerability. Present-day American society and its institutions often exacerbate these feelings. For example, the mass-produced is valued more, the man-made less than ever; both the government and colleges are becoming larger and more impersonal; and the individual's sense of being insignificant and helpless is increasing.

The process of attaining skill in the trades and professions seems to them at least uncomfortably long and sometimes irrelevant to their future activities. For many members of minority groups it is impossible. School is the only place most young people can be sent for training. When school programs are imaginative, relevant to past experiences and future expectations, and led by teachers whom the students can like and respect, students participate with enthusiasm. When curricula are dull, teachers uninspired, listless, underpaid and overworked, physical facilities inadequate, and support from parents and the community lacking, the students can hardly be expected to be enthusiastic about their education.

Moreover, young people are keenly aware of social injustice, the threat of nuclear war, and the ineffectiveness or downright hypocrisy of many of those in authority. They are confused about authority, not clearly appreciating that responsible authority permits a democracy to exist whereas irresponsible authority, or authoritarianism, is destructive of the democratic process. As a result of their confusion they often tend to reject all authority. Sometimes their criticisms of society become so generalized that they reject most conventional values, refuse to participate in a system they see as pernicious, and focus instead, with drugs as their instrument, on their own subjective values and experience; this is the meaning of the phrase *turn on, tune in, drop out,* eg, marihuana often seems to them to produce a sense of greater fellow-feeling and better communication.

Because of their psychological effects, drugs temporarily help young people to escape their feelings of being alienated, under pressure, and helpless; simultaneously, the act of drug taking places each individual in a group of kindred spirits. He may feel better related to others even as objective observation shows him to be even more isolated than before.

Many young persons have not had the advantage of a family life in which they were trained for responsibility. One group of young, former drug takers who appeared on a David Susskind show agreed that if their parents had been concerned about them and had been strict in setting standards for them to follow, the possibility of their becoming dependent on drugs would have been decreased. In their discussion they formulated the principle that concern without discipline is of little value and discipline by parents who do not really care about their children is useless.

Drug use and its associated forms of behavior have certain built-in limitations. They provide little permanent satisfaction. Short-range satisfaction is derived from peer group approval and publicity. Moreover, the overzealous (and sometimes blatantly wrong) activity of some law enforcement officials serves as justification or "proof" of the rightness of their own positions. The exaggerated concern accorded them by their frustrated and bewildered critics may encourage them to persist with their self-defeating activities longer than they otherwise would prefer. Since most of them seem to have no fixed income other than what they get from their families, and are not developing a capacity for responsible em-

ployment, they may ultimately tire of their vagabond existence. There is considerable evidence that many young people toy with various forms of asocial or antisocial behavior only to return to more responsible modes of living, often with strong dedication to the righting of social wrongs.

The methods by which alienated young people choose to show their disdain for conventional values make rational thinking about their behavior difficult for older people. Whereas the young usually put high priority on love, peace, idealism, and similar attributes, their appearance and behavior often seem to be peculiarly designed to attract criticism. Long hair, outlandish fashions, lack of cleanliness, sexual laxity, disrespect for personal and public property, and a manner which appears arrogant and impulse-ridden frequently accompany experimentation with drugs. Irritation with specific forms of disapproved behavior tends to divert attention from the fundamental problem, ie, the dissatisfaction of these people with the values they observe and their subsequent alienation, and direct it toward changing or forbidding the behavior considered undesirable. Attention to the reasons for alienation and disenchantment, if it is to be effective, must include respect for the individuals involved, and tolerance (but not necessarily approval) of their behavior.

The Physician's Role

In their desire to express themselves, the majority find satisfaction in their studies, their school associations, and the support they get from their families and friends. Others not so fortunately situated cannot resolve their conflicts (usually they are not even aware of what the conflicts are) and express themselves in delinquent acts, or poorly controlled impulse expression, or by showing no sense of social responsibility (or any combination of these). An even more serious result of the failure to develop a way of life that yields satisfaction is the development of mental or emotional illness. A new and disturbing aspect of hallucinogenic drugs is that they may permanently impair the judgment of people who experiment with them. These potentially capable young men and women could thus become permanent casualties of their struggle to give meaning to their existence, and we should find methods of preventing such a disaster if possible. Physicians are in a particularly good position to help educators develop such methods and should, therefore, acquaint themselves with the issues involved.

If we approach the solution of the drug problem with single-minded determination to eliminate the drugs, or prevent their use by young people, we run the risk of adding to our difficulties rather than minimizing them. Drugs should be viewed as an incidental factor, considered in the same class as other forms of "acting-out" behavior (disrespect for property, acting on impulse, accident proneness, delinquency), and not as the central problem. This does not lessen the importance of appropriate laws for the control of potentially harmful drugs and support of law enforcement agencies. In showing such support, however, the physician should not be the punitive agent, thus depriving troubled people, who happen to use drugs as one of their attempts to deal with their conflicts, of one of their sources of effective help.

The American Medical Association, through its Committee on Alcohol and Drug Dependence and the Council on Mental Health, has prepared a series of statements on all the drugs about which medical authorities are concerned.

Those on narcotics,[6] barbiturates,[7] amphetamines,[8] marihuana,[9] and LSD[1] have been published in *JAMA*. An extensive monograph on alcoholism and a summarizing statement for the general public about the drug problem have been published separately.

Armed with the information contained in these publications, every physician can be of inestimable help to educators, law enforcement officials, clergymen, parents, leaders of young people's organizations, and others in each community who have a responsibility for keeping drug usage within reasonable and appropriate limits. Success in such an endeavor will depend to a large extent on gaining the understanding and support of the vast majority of young people who are interested in approaching the solution of problems facing them in sound and intelligent ways. Giving them the facts in terms that can be clearly understood, without moralizing, in combination with efficient enforcement of the laws covering distribution of these drugs, appears to be our most important weapon.

A list of references will be supplied upon request.


aaron sophia

your medical faculty at work

by John Sargeant
Executive Secretary

The Executive Committee of the Faculty met on September 5, 1968, in Ocean City, Md., and took the following actions:

1. Nominated the following men to the State Board of Health and Mental Hygiene for possible appointment to the Advisory Council on Mental Hygiene:
   Clayton Norton, MD, Annapolis
   E. Gordon Grau, MD, Towson
2. Approved the Executive Secretary assisting in technical matters the Advisory Committee to the Governor's Inter-Agency Health Planning Council.
3. Designated official representatives to attend a closed session on Chiropractic sponsored by the AMA to be held in Chicago in October.
4. Approved expansion of the present Study of Anesthesia Deaths in Baltimore City to a Statewide program to be coordinated in cooperation with the Maryland Society of Anesthesiologists and the State Health Department.
5. Approved mailing of a U. S. Treasury Department letter to all members urging them to participate in the purchase of U. S. Savings Bonds. The letter will be enclosed with a future Faculty mailing.
6. Authorized financial aid to an incapacitated physician at the rate of $75 per month; for a 12-month period.
7. Instructed that the current policy with respect to use of the Faculty's membership mailing list be reevaluated and recommendations be made for any changes, if such are found necessary.
8. Appointed a Committee to meet with appropriate Woman's Auxiliary officers for the purpose of establishing the extent of services that should be provided to the Woman's Auxiliary to the Faculty.
9. Authorized the attendance of William L. Stewart, MD, as Faculty representative, to attend a National Conference on Continuing Medical Education sponsored by the AMA, in Chicago. The Faculty will underwrite the expenses.
10. Heard of a U. S. Department of Health, Education and Welfare Regional Conference on Health Care Costs, scheduled for Harrisburg, Pa., on December 10 and 11, 1968.
11. Approved of providing technical assistance to the Regional Planning Council (Baltimore Metropolitan Area) insofar as is possible.
12. Authorized Russell S. Fisher, MD, to represent the Faculty at a Conference on Medicolegal Issues Related to Tissue Transplantation scheduled for Washington, DC, on September 30, 1968.

The Council of the Faculty met on September 5, 1968, in Ocean City, Md., and took the following actions:

1. Approved minutes of previous meetings; and adopted financial statements through June 30, 1968.
2. Announced receipt of $1,319.06, representing 1967 royalties from publication of books by Henry P. Laughlin, MD, which is to be deposited to the credit of the Laughlin Fund.
3. Ratified legal defense for certain cases; and heard of the settlement of another case.
4. Recommended to the State Board of Health and Mental Hygiene, that Frederick M. Johnson, MD, of La Plata, Md., be named to the Medical Assistance Advisory Committee to replace J. Roy Guyther, MD, of Mechanicsville, who was forced to resign because of the pressure of work.
5. Held a discussion of Regional Medical Program Policies in connection with grant applications and approval of such applications. The Council decided that it was too early to determine whether community hospital grant applications were being ignored and university hospital grant applications approved. It referred this matter for further study, if applicable, to the Faculty's Committee on Postgraduate Education, Preventive Medicine and Public Health.
6. Approved the mailing of Executive Committee and Council minutes to all Council members as soon as practical after their preparation.
7. Recommended Emeritus Membership for various members to the House of Delegates.
8. Adopted a proposal for legislation dealing with prescribing of drugs under the Medical Assistance Program.
9. Adopted Journal advertising policy that no advertising should be accepted for the Journal that is in direct conflict with programs or services offered by the Faculty or groups or Trusts sponsored by the Faculty.
10. Received for information a tax ruling dealing with deductibility of expenses in connection with the Faculty-sponsored cruise conventions. Copies are available to individual members on request.
11. Declined to approve an addition to the proposed Medical Practice Act, that would have permitted the Board of Medical Examiners to issue temporary permits to qualified physicians to practice in areas of need as determined by the Board.



MEDICAL NEWS

H. Gray Reeves, MD, of Salisbury, has been appointed to the Board of Trustees for the State Colleges. He will replace **Mrs. Thomas H. White, Jr.,** on the nine-member board.

Dr. Reeves is a former president, vice president and secretary of the Wicomico County Medical Society.

* * *

Victor E. Albites, MD, is now associated with **Paul F. Guerin, MD, Watson Kime, MD,** and **Edward L. Sherrer, Jr., MD,** in the clinical practice of Laboratory Medicine at 1010 St. Paul Street in Baltimore.

* * *

David E. Rogers, MD, former Professor and Chairman of Medicine at Vanderbilt University, has been appointed vice president for Medicine and Dean of the Medical Faculty of The Johns Hopkins University, and Medical Director of The Johns Hopkins Hospital. He succeeds **Thomas B. Turner, MD,** who retired June 30.

The new dean earned his MD degree at Cornell University Medical College in New York, and held assistant and associate professorships there.

He is a leading figure in infectious disease research.

* * *

Albert Steiner, MD, was a lecturer at The Medical Association of Croatia in Zagreb, Yugoslavia, on September 3 and 4. He also served as lecturer and teacher of a course in rhinologic surgery, sponsored by the American Rhinologic Society, at the ORL Clinic of the General Hospital of Zagreb, Yugoslavia, September 4-7.

While abroad, Dr. Steiner also attended a symposium on rhinology in Belgrade on September 9.

* * *

Louis V. Blum, MD, Chairman of the Appreciation Committee, has announced that the "**Dr. John A. Askin Pediatric Research and Post Graduate Institute**" will be founded in Israel.

The Institute will be established under the auspices of the Israel Histadrut Council of Baltimore in conjunction with colleagues, friends, patients of Dr. Askin, and the Guild for Infant Survival.

Dr. Askin has been interested in furthering research in Pediatrics through a Post Graduate Exchange Program between The Johns Hopkins Medical School and Hospital and the State of Israel for many years.

* * *

Honorable mention in the 1968 Research Contest of the American Diabetes Association has been won by two house staff members at the University of Maryland Hospital. **Francine Camitta, MD,** Associate Chief Resident in the Department of Medicine, and **Timothy Gray, MD,** Senior Assistant Resident, won the award for a report of their studies, which were conducted in the hospital's Clinical Study Center.

* * *

Rex Boland Conn, Jr., MD, Professor of Pathology and Director of Clinical Laboratories at the West Virginia University Medical Center, is the new director of a reorganized Department of Laboratory Medicine at The Johns Hopkins Hospital. Dr. Conn will also hold an appointment in The Johns Hopkins University School of Medicine as Professor of Laboratory Medicine in a newly created division of the Department of Pathology.

In his new position, Dr. Conn will administer the Hospital's clinical laboratories, which are staffed by more than 200 people. He also will begin work to form a school of medical technology and a residency training program in clinical pathology.

* * *

The U. S. Senate concurred with the House amendments to the **Health Manpower Act** (S. 3095) thus clearing the bill for the President's signature.

As passed, the bill extends for two years the Health Professions Educational Assistance Act Amendments, with its program of grants for the construction of teaching facilities for medical, dental, and other health personnel, institutional and special project grants, and student loans. Also extended for two years is the Nurse Training Act, providing for grants to assist in the construction of new educational facilities, special project and institutional grants, and loans to nursing students. Schools of nursing could be accredited by a body approved for the purpose by the Commissioner of Education. The Allied Health

Professions and Public Health Training Act is extended for one year and the program of grants for the construction of health research facilities is extended for two years.

* * *

The Council of the American College of Radiology has selected **John M. Dennis, MD,** as vice-chairman. Dr. Dennis was elected a Chancellor some time ago and has served as Examiner for the American Board of Radiology and in many other capacities within his specialty.

He has also served as President of the Maryland Division, American Cancer Society and as President of the Medical Board of the University of Maryland Hospital. He is now Professor and Head of the Department of Radiology at the University of Maryland Hospital and School of Medicine.

* * *

The U. S. Senate passed and cleared for the President a bill which establishes a **National Eye Institute in the National Institutes of Health.** It accepts the language of the House-passed version. During debate by the House, the bill was amended to change the name of the National Institute of Neurological Diseases and Blindness to the National Institute of Neurological Diseases.

* * *

A special survey tour of Israel on behalf of the "Dr. John A. Askin Pediatric Research and Post Graduate Institute" is being made by **Robert E. Cook, MD,** Professor of Pediatrics, The Johns Hopkins Medical School and Hospital.

Dr. Cook will be in Israel for a two-week period to confer with leading medical personnel and Histadrut leaders to formulate plans for the Askin Institute.

* * *

The appointment of **John H. Moxley, MD,** as the new dean of the University of Maryland School of Medicine, and lecturer in medicine, has been announced by University President **Wilson H. Elkins, PhD, and Albin B. Kuhn,** chancellor of the Baltimore campuses.

The appointment is effective as of June 1, 1969.

At present, Dr. Moxley is assistant to the dean of faculty of medicine at Harvard University. At age 34, he will become the youngest medical school dean in the United States.



Dr. Moxley will succeed **William S. Stone, MD,** who is retiring next June after serving 15 years as dean of the School of Medicine.

When he announced the appointment, Dr. Elkins said, "Dr. Moxley is a man of exceptional ability and great promise in the field of medical administration. He will come to the University of Maryland with the highest recommendations and will be welcomed with enthusiasm. In these times, when physician-administrators are in short supply, the university is fortunate to secure the services of Dr. Moxley. . . ."

Dr. Moxley said he is highly enthusiastic over the continuing development of the Baltimore City campus and the new Baltimore County campus. He looks forward to closer teaching ties between the two campuses, which he believes will enhance the intellectual atmosphere of both.

"The separation of academic groups within a university structure tends to create a vacuum that restricts free intellectual exchange," he said.

Dr. Moxley was awarded his AB from Williams College in 1957, and his MD from the University of Colorado School of Medicine in 1961. He interned in medicine at the Peter Bent Brigham Hospital in Boston.

From 1963 to 1965 he was a clinical associate at the National Cancer Institute, NIH, where his research involved the use of chemotherapy and x-irradiation in the treatment of Hodgkins Disease, and in kinetics of leucocytes in various types of leukemia. In 1965, he returned to Boston as senior resident physician at the Brigham Hospital.

Dr. Moxley is a member of the Lymphoma Task Force of the National Cancer Institute, junior associate in medicine at the Peter Bent Brigham Hospital, and a member of the courtesy staff of the Cambridge, Massachusetts City Hospital. He has been an instructor in medicine and assistant to Robert H. Ebert, MD, dean of the Harvard Medical School, since 1966. In 1966-67 he served as a staff member of the National Advisory Commission on Health Manpower.

ROBERT E. FARBER, MD, MPH, COMMISSIONER

Baltimore City health department

Reducing Teen-age Pregnancy

A new attack on the city-wide problem of unplanned births to girls 16 years of age and under has been initiated by the City Health Department in the lower Park Heights area of Baltimore City.

Financed by a grant of $25,000 from the Thomas Wilson Fund, the program will organize services to improve the social environment of girls 10 to 16 years old in that neighborhood. Those enrolled in the program will receive instruction in family-life education and in career advancement. They will be taught such skills as sewing, knitting, and arts and crafts, and will participate in recreational activities such as swimming, cook-outs and games. A tutorial project through the use of volunteer college women is planned for the fall. The project will also involve neighborhood mothers who will be called upon to assist in the implementation of planned activities.

Counseling services and medical support will be provided at Sinai Hospital and by the Maternal and Child Health Services at the Druid Health District Building, 1515 West North Avenue.

This project will involve a close working relationship between the City Health Department and the Maryland League of Women's Clubs, the Lower Park Heights Area Council, the Loyola Neighborhood Improvement Association and other neighborhood improvement groups.

According to Matthew Tayback, ScD, Deputy Commissioner of Health, there are about 1,000 unplanned teen-age births each year in Baltimore City. It is his opinion that such a program could well reduce unplanned births by as much as 50%.

Project Coordinator is Mrs. Margaret B. Pollard, Health Educator Consultant for the city's Comprehensive Health Services for Children and Youth Project 606, telephone 752-2000, extension 2779.

Gonorrhea Project

A new project aimed at the reduction of Baltimore's most frequently reported communicable disease—gonorrhea—has been established by the City Health Department with the assistance of a U.S. Public Health Service grant. The program will involve public and private clinics where patient services include pelvic examinations of large numbers of women.

Under the direction of James E. Peterman, MD, Director of the Bureau of Communicable Diseases, the project will determine ■ hidden gonorrhea in women through a gonorrhea culture screening program ■ the distribution of infection in various socio-economic levels of the city's population and ■ the value as a case-finding technique.

In 1967, 5,370 cases of gonorrhea in men and 1,393 in women were reported. It is believed that there is a much greater incidence of gonorrhea in women than indicated by these annual figures. Through the new project, previously unrecognized gonorrhea will be identified and adequate treatment started by private physicians and cooperating agencies including City Health Department clinics. The Baltimore City Branch of the State Health Department Laboratories will perform the required laboratory work. Specifically, within a one-year period it is hoped that 35,000 cervical specimens will be collected and tested.

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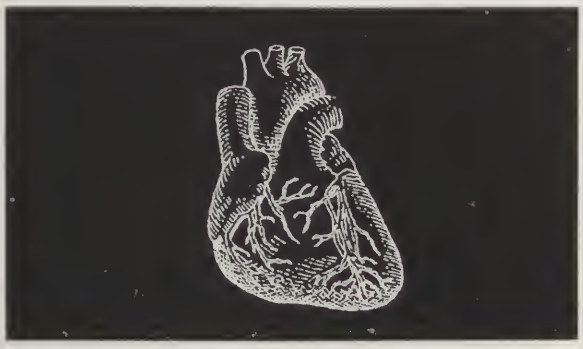
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JERRY SALAN, MD, EDITOR

A Service of the Heart Association of Maryland

the heart page

Hyperthyroid Heart Disease

In hyperthyroidism there is an increased demand of the myocardium and most other tissues for oxygen. In addition, the thyroid hormones have a direct effect upon the myocardium so that myocardial contractility, automatically and excitably are augmented. There are increases in heart rate, systolic blood pressure, cardiac output, mean pulmonary arterial pressure, cardiac work index for both left and right ventricles and coronary blood flow. The hemodynamic responses during exercise are normal, but when congestive heart failure is present, although the cardiac output is normal or elevated, there is an inadequate response to exercise. In certain species of animals given excess thyroid hormones there is an exaggerated response of the heart to epinephrine. However, thyroid hormones do not augment hemodynamic responses to catecholamines in man, and in hyperthyroidism the sympathetic nervous system is not responsible for the elevated oxygen consumption.

JOHN G. WISWELL, MD
Professor of Medicine
University of Maryland School of Medicine

In the hyperthyroid patient there is a bounding precordium with loud, forceful heart sounds. There may be a systolic murmur both at the apex and the base which may suggest the presence of rheumatic heart disease or congenital heart disease. Frequently, the presence or absence of other organic heart disease cannot be established until the patient has returned to the euthyroid state. Occasionally, there is a grating pulmonic systolic sound which resembles a pericardial friction rub and is heard best at the end of expiration in the second left interspace; it disappears with inspiration and is probably pleuropericardial, but the exact cause is obscure. Cardiac enlargement and congestive heart failure may be found even in young patients with or without the presence of other underlying heart disease. Mild peripheral edema may be present without other signs of congestive heart failure. Precordial or substernal pain resembling angina may occur and disappear following

therapy. This is probably due to relative myocardial ischemia from the increased work load of the heart even though coronary blood flow is increased. The incidence of coronary disease and myocardial infarction is about the same in hyperthyroid patients as in the general population.

Premature beats are frequent and atrial fibrillation occurs in approximately 10% of patients. Atrial flutter, nodal tachycardia and paroxysmal supraventricular tachycardia are uncommon. It is important to evaluate thyroid function in any patient with atrial fibrillation whether or not there is a history of previous heart disease. The electrocardiogram may show varying degrees of heart block. There may be peaked P-waves with a prolonged P-R interval, a shortened Q-T_c interval (corrected for heart rate), and ST-T changes resembling those found in myocarditis or pericarditis. No specific pathologic changes have been found in hearts of patients who have died with hyperthyroidism.

Hyperthyroidism should be suspected when the following are present:

1) **paroxysmal or persistent atrial fibrillation**
2) **unexplained sinus tachycardia which does not improve on standard therapy**
3) **inadequate response to digitalis preparations (this is due in part to increased metabolism of digitalis in hyperthyroidism)**
4) **occurrence of digitalis intoxication prior to cardiac compensation or slowing of the heart rate**
5) **persistent congestive heart failure in spite of adequate cardiac therapy**
6) **dissociation between the patient's clinical well-being and the degree of cardiac impairment.**

In the younger patient with cardiac involvement, large doses of antithyroid drugs, eg, 600 mg of propylthiouracil or 60 mg of tapazole daily, should be used to bring the hyperthyroidism under control as rapidly as possible. Older patients may be treated with radioiodine. However, since the effect of this does not take place for two to four months, patients should be given an antithyroid drug beginning four to five days after the administration of the radioiodine and continuing for about two months. Reserpine and guanethidine, which deplete tissues of catecholamines, may be useful for the first few weeks. These agents cause some decrease in pulse rate and pulse pressure and some improvement in the subjective symptoms of nervousness, fatigue, palpitation, dyspnea and heat intolerance. There is little reduction in oxygen consumption, and cardiac index and stroke volume do not return to normal. There is also no improvement in thyroid function. The use of propranolol, a β-receptor blocking agent, is not recommended; it does not induce any greater fall in heart rate of patients with hyperthyroidism than in those with a simple anxiety state and its use is absolutely contraindicated in patients with cardiac decompensation.

In the presence of heart failure, the dose of digitalis preparations may need to be increased, but not to the point of toxicity. The heart rate may not fall to normal until the hyperthyroidism has improved. In some patients atrial fibrillation ceases spontaneously as they become euthyroid. Otherwise, no attempt should be made to convert the rhythm to normal until the patient has become euthyroid. At that time the patient can be given a trial of quinidine; if this fails, then electrical cardioversion may result in normal rhythm in many patients. The patients should be hospitalized for this purpose so that careful monitoring with the electrocardiogram can be performed. In approximately 25% of older patients with hyperthyroidism, atrial fibrillation may persist in spite of the above measures even though the patient is euthyroid. When the patient has returned to the euthyroid state, careful examination for the presence of underlying heart disease should be performed.

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WILLIAM J. PEEPLES, MD, MPH, COMMISSIONER

Maryland State department of health

HIGHLIGHTS

Summer Medical-Dental Projects Vary

The summer projects authorized by the State Health Department for The Johns Hopkins University and University of Maryland medical and dental students covered a variety of interests. Summaries presented August 13 at the 16th annual seminar dealt with the following subjects:

Something Out of the Air—examining the physical effects of certain air pollutants with reference to air quality control, Anne Arundel County Health Department.

Prenatal and Perinatal Factors Involved with Exceptional Children—Exceptional Children's Clinic, University of Maryland.

The Health Survey of Ilha da Conceicao, Niterio, Brazil—with special reference to nutrition and child health, by three students, under the Department of Preventive Medicine and Rehabilitation, University of Maryland.

Nutritional Development of Baltimore Children—under the Baltimore City Health Department.

A New Directory—of services available to physicians in Prince George's County through the County and State Health Departments.

Migrant Project, Wicomico County, 1968—by two students, under the Wicomico County Health Department.

Missed Appointments in a Comprehensive Pediatric Clinic—under the University of Maryland Community Pediatric Center.

Clinical Judgment and Decisions in the Emergency Room—under Baltimore City Hospitals.

Glue Sniffing—An Epidemiological Survey in Maryland—Part II—under the Department of Physical Medicine and Rehabilitation, University of Maryland.

An Evaluation of the Rehabilitation of Spinal Cord Injured Patients—under the Department of Rehabilitation Medicine, Montebello State Hospital.

Health Care Survey—Project 606 Southeastern Health District—under Child Health Services, Baltimore City Health Department.

The Natural History of Urinary Tract Infection Following the Ileal Loop Diversion—under the Department of Medicine, Montebello State Hospital.

A Descriptive Study of Programs for Prince George's County Residents Admitted to Western Maryland State Hospital—under Prince George's County Health Department.

Dental Epidemiology: A 30-Year Follow-up of Hagerstown Dental Reports of the 1930's—under the Department of Community Denistry, University of Maryland.

The Panorex Program—under Dental Services, the Community Pediatric Center, University of Maryland.

Dental Needs, Services, and Education of Pre-School Children in Baltimore—in two parts, each by one student under the Dental Care Division of the Baltimore City Health Department.

Preliminary Report on Birth Certificate Follow-up

The Birth Certificate Follow-up Program, conducted by the Division of Communicable Diseases as part of the Maryland Immunization Project, was started in April, 1967 for children born in January of that year. In Phase A of this program, immunization promotional cards are sent to parents of new-born children who have a residence in the counties of Maryland. The first card is sent when the baby is three months old. If there is no answer in three months, a second card is mailed. If there is still no answer by the time the child is eight months old, personal contact by telephone or field visit is initiated.

Preliminary analysis of the first phase of the program for children born in January, February, March, and April, 1967, revealed that the parents of 11,576 children were sent reminder cards; 10,509 (91%) replied or were located by personal contact; 1,067 (9%) could not be located.

Replies to cards or personal contact indicated that 9,163 (87%) of the children had started a basic immunization series. Of those who had started the series, 7,148 (78%) were receiving their shots in a private physician's office; 1,111 (12%) in county health department clinics; and 904 (10%) in military clinics.

The report also indicates that 1,346 children (13%) had not started their basic immunization series at the time of inquiry.

Hospital Commission Expires

The functions and responsibilities of the Maryland Hospital Commission, disbanded by action of the Governor as of July 1, have been taken over by the Health Department's Division of Medical Facilities Development, under the direction of Mr. Allan F. Antisdel, former Executive Secretary of the Commission. With the original $50 million in State loan funds committed to 14 hospital building projects, except for some $23,000 reserved to cover bond sale costs, the Commission's loan recommendation function has been completed.

On-site review of construction progress (required when projects reach 25, 50, 75, and 100% completion stages) will continue over approximately three years. Six of the 14 hospitals have yet to reach the 25% progress stage when an agreement will be prepared and 25% of the committed funds transferred.

Additionally, the Division must see that insurances are kept in force, must maintain files and correspondence, and twice a year must provide the Treasurer's office with information as to bonds needed to cover disbursements.

An End to Burning Dumps

The largest open burning dump in Maryland was closed July 1, when Cumberland began hauling its refuse to the Frostburg sanitary landfill, operated by the Division of Solid Wastes as part of a three-year demonstration project to test the use of abandoned strip mines for this purpose. The fill now serves a population of about 50,000 and to date has produced no evidence of water pollution, rodents, vermin, or unpleasant odors.

It is hoped that the continued successful operation of this landfill will help to dispel the fears of residents in areas where sanitary facilities of this type are proposed. Strong objection was recently voiced at a public hearing conducted by the Chief of the Division of Solid Wastes in Allegany County. Some 300 persons appeared in opposition to a land reclamation company's proposal to establish a sanitary landfill in three adandoned strip mines on Big Savage Mountain, to which refuse from Baltimore would be baled and shipped by rail. The area would eventually be developed for resort use.

Teen-agers Learn About Health Careers

Ninety-two high school students, volunteers in Maryland hospitals, recently attended the second annual all-day conference on Health Careers at the University of Maryland Hospital. Needs and opportunities for health personnel on all levels in private practice, public health, hospitals, schools, business and industry were described by speakers from City, State, Federal, and private hospitals; the USDHEW; and the Department. Believed to be the first program of its type in the State, the conference is sponsored by the Health Department, the Maryland Council of Directors of Volunteers and the Maryland Association of Hospital Auxiliaries.

Civil Rights Study Completed

With a view to decentralizing the process of investigation of medical facilities for compliance with Title VI, the Civil Rights Act of 1964, the Federal Civil Rights Commission several months ago selected Maryland for a pilot study in "on site" review procedures. Based on a preliminary draft

of their findings, conferences are under way to determine the respective roles of State and Federal agencies in such investigations, and to establish recommended procedures for the Commission's use here and in other states.

Nuclear Plant Site Visited

As part of the Division of Radiological Health's Environmental Surveillance Program, considerable attention is given to existing and proposed nuclear power plants and other nuclear facilities. Several meetings have been held with officials of the Baltimore Gas and Electric Company to discuss the proposed Calvert Cliffs nuclear power plant, with respect to environmental surveillance and emergency plans.

As a preliminary step, Division representatives and personnel from the Nuclear Facilities Section of the National Center for Radiological Health recently visited the Calvert Cliffs site, located on the western shore of the Chesapeake Bay, southeast of Prince Frederick in Calvert County.

The Division of Radiological Health recently served as host to the Annual Region III National Center for Radiological Health Symposium in Baltimore. Region III comprises the District of Columbia, Kentucky, Maryland, North Carolina, Puerto Rico, Virginia, and West Virginia.

PKU Nursing Information in Preparation

The Nursing Subcommittee on Hereditary and Metabolic Diseases has been compiling a packet of materials for the use of public health nurses working with children having a positive Guthrie test reaction and/or under treatment for phenylketonuria. Local health department nursing staffs have been asked to submit to the Division of Nursing any questions they have received from children or parents, as well as questions they themselves may have, which would be helpful in developing guidelines and reference materials.

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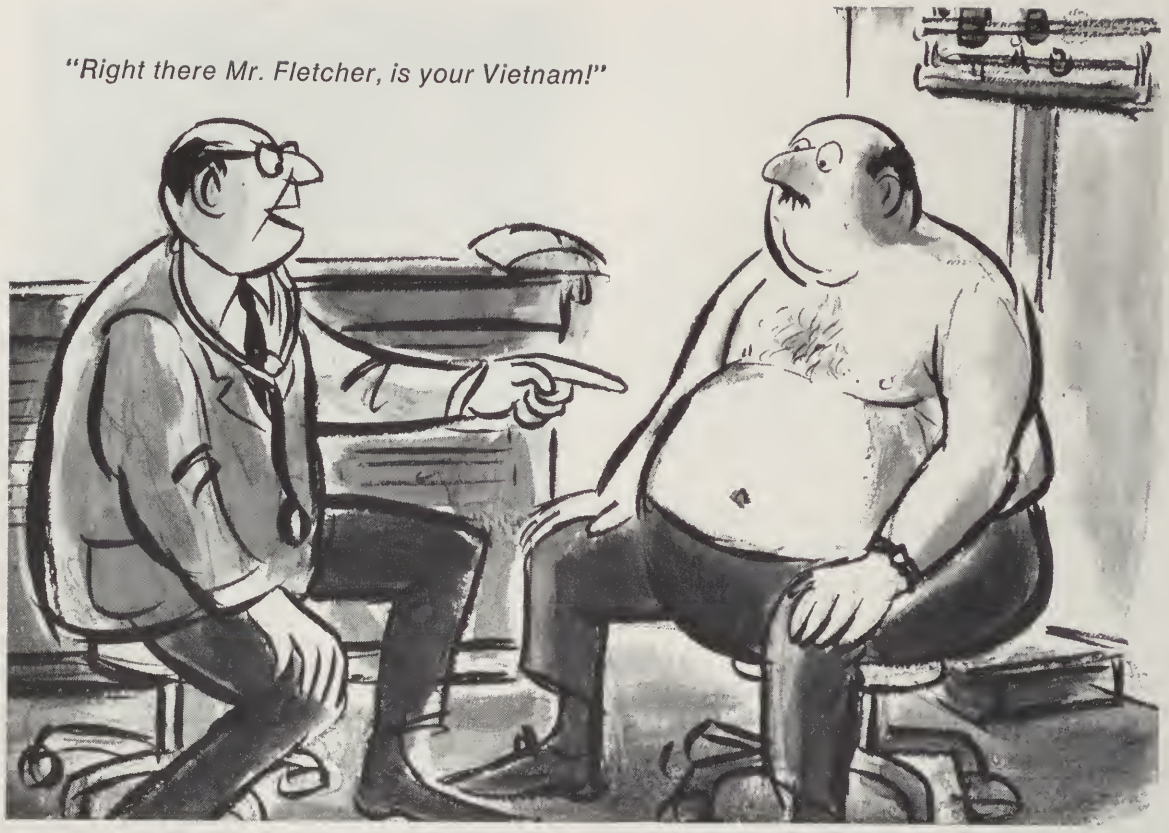
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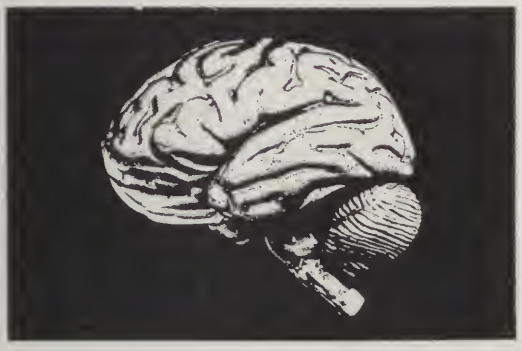
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JAMES E. CARSON, MD, COMMISSIONER
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Maryland State department of mental hygiene

Capacity, Patient Population Size and Occupancy Rates

Latest patient data indicate that Maryland's mental hospitals operated at an average 105.8% of capacity while institutions for the retarded were at a 116.0% level. Comparable data based on each hospital's highest daily patient figures during the year indicate an effective overcrowding of 11.2 and 20.0%, respectively, for these two types of facilities. Statistics for the year ending June 30, 1968 are summarized in the following table.

	Total	Psychiatric Hospitals	Institutions for Retarded
AVERAGE PATIENT POPULATION	10,800	7,640	3,160
MAXIMUM PATIENT POPULATION	11,300	8,032	3,268
CAPACITY*	9,945	7,222	2,723
OCCUPANCY RATE			
BASED ON AVERAGE POPULATION	108.6	105.8	116.0
BASED ON MAXIMUM POPULATION	113.6	111.2	120.0

* Based on American Psychiatric Association recommended 80 square feet per bed in single rooms and 70 square feet per bed in dormitory areas.

Occupancy rates varied between hospitals and within units of the same facility. While maximum overcrowding, 23.2%, occurred at Springfield virtually all of the hospitals operated at 100% or more of indicated capacity. None were less than 90%. All of the psychiatric hospitals have experienced a gradual reduction in occupancy rates averaging 2% per year, primarily resulting from a decreasing patient population. However, comparable data for Maryland's two institutions for the retarded show virtually no change in recent years.

Nearly 20 years have elapsed since a series of newspaper articles on "Maryland's Shame" produced a commitment to extensive, continuing remedial action. The current existence of substantial overcrowding, despite large-scale construction and a 20% decline in the average size of the patient population, should be a matter of grave concern. Clearly, this chronic situation is neither conducive to effective patient treatment nor to employee morale. Elimination of this problem is attainable either through a continued large-scale building program or by the development of a network of community-based programs and services providing an alternative for hospitalization.



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DOUGLAS G. CARROLL, MD, EDITOR

rehabilitation notes

Measurement of Performance in Rehabilitation*

"If one wishes to discuss with any hope of reaching agreement what one means by knowledge —or preferably *knowing*—the two main topics of the agenda for our *public* symposium will be *recognition* and *communication;*" Lancelot Hogben in *Statistical Theory.*

Problems in Classification of Diseases, Impairments and Syndromes

In attempting to identify factors in the diagnosis which are important in predicting the possibility of improving performance, one must take into consideration not only the duration, suddenness of onset and prognosis for life, but also those factors in disease which may influence future performance. We have attempted to orient this prediction around the impairment for which the patient was referred to the Department of Physical Medicine and Rehabilitation, rather than around the complaint causing admission to the hospital. When these two are the same, and there is no other disease, the patient is placed in Diagnostic Group I. When these two are the same, but there is an associated disease which will probably cause no interference with function within several months (for example, asymptomatic hypertension, mild diabetes mellitus), then the patient is placed in Diagnostic Group II. Any other combination of diseases is placed in Diagnostic Group III.

This division of cases into different Diagnostic Groups allows comparison of patients with the same diagnosis, type of onset and duration and identifies the presence or absence of associated diseases.

There has been growing interest in how to use a diagnosis to describe more clearly the multiple situations which it may symbolize. Wilson, Lawson and Brass[1] have suggested that diagnoses be identified in relation to whether they are "pathologically active at the time of admission and contributing to the need for admission" ("existing"), whether they are old but still significant clinically ("old"), whether they occurred shortly before death ("terminal"), or whether they symbolize a disease which, at the time, produced no symptoms and was not of prognostic significance ("noncontributory").

Feinstein[2] also is concerned with a qualitative refining of the use of diagnostic terms. Of particular interest is the problem of comparing different groups of patients with the same diagnosis but with very different manifestations, duration and severity. How and when is a disease first discovered and diagnosed? The patient whose disease is discovered as a result of the chief complaint is identified as the "complainant." The patient in whom the same disease is discovered accidentally has a quite different course and is distinguished by the term "lanthanic" patient. Different stimuli bring patients to the doctor. The "iatrotropic stimulus" is usually the same as the chief complaint. A patient may, however, have prolonged weight loss and weakness but does not seek medical care until he sees a cancer program on television.

* This is the sixth of a series of notes on "Rehabilitation of Chronic Impairments in Adults."

In this case, the "iatrotropic stimulus" would be the information on the television, whereas the chief complaint would be weakness and weight loss.

Finally, the homogeneity of the patients within a diagnostic group must be considered when estimating the prognosis either for life, physical or mental functioning. A homogeneous diagnostic group is one where all the patients have very similar signs, symptoms and laboratory findings. Homogeneity of diagnostic groupings will depend on how accurately the diagnosis can be made and how stereotyped the anatomical, physiological, pathological features and the course of the disease. A diagnosis of intertrochanteric fracture of the hip is considered to be a homogeneous diagnostic group. The diagnosis is made accurately from history and physical examination and supported by X-ray observation. The features giving rise to possible complications are well known, and the course of healing is generally predictable. Thus the prognosis for life, physical and mental function can be reached relatively accurately, particularly in the young, uncomplicated case.

Examples of heterogeneous diagnostic groups are rheumatoid arthritis and rheumatic fever (where various major and minor diagnostic criteria are used), disseminated sclerosis (where diagnosis may be difficult and the course is notoriously unpredictable), hemiplegia (which is a syndrome caused by a number of different diseases). In all these situations, the anatomical, physiological and pathological features and the course of the disease are not stereotyped and may not be similar in different patients with the same diagnosis. To test our own classification system for the classification of diseases[3] two physicians independently classified ten patients referred to the Department of Physical Medicine and Rehabilitation for evaluation and treatment. Using the method described previously for classifying patient into different diagnostic rubrics and different diagnostic groups, there was agreement on all ten patients. This was an unselected group of patients taken as they appeared serially in the Department. In each case, the correct diagnostic rubric was selected. Furthermore, the cases were put into the correct diagnostic group depending on whether there was only one disease, syndrome or impairment (Diagnostic Group I) or whether in addition to the major diagnosis bringing the patient to the Department of Physical Medicine and Rehabilitation there was a symptomatically unmanifested disease (Diagnostic Group II), or whether there was in addition to the disease bringing the patient to the Department of Physical Medicine and Rehabilitation an entirely different disease which was causing the patient symptoms or might interfere with his improvement in independence (Diagnostic Group III).

Some Problems in Measurement of Performance

The identification and definition of the physical demands of daily life (Activities of Daily Living) by Deaver and Brown[4] in 1945 has been a fruitful step in shifting emphasis from preoccupation with the "anatomical" and "pathological" impairment of patients with injuries and disease to an emphasis on performance. Progress in standardizing tests for Activities of Daily Living (ADL) has advanced.[5, 6] The ADL is open to a number of criticisms:

☐ Matching the test with the patient's situation at home:

The first question arising in relation to tests of ADL is how well the tests performed in a hospital correlate with what the patient actually does at home, in the nursing home or on the job. The final goal of treatment is to have the patient at his maximal physical, medical, psychiatric, financial, familial and vocational independence in a specific environment, which is not the hospital. Is it possible to select activities which are common to all patients under differing home situations?[7]

For five years we have used the ADL evaluation as the basic information in regard to the physical needs of patients being discharged to nursing homes, foster homes, a chronic hospital, as well as to the patient's own home. Decisions as to the nursing needs, wheelchair, toilet, crutch and walker needs are based on the ADL evaluation. Although there have been a few patients who had falls in the home following discharge, by and large the ADL evaluation has been extraordinarily helpful and accurate in predicting the physical needs of the patient after discharge.

☐ Tests are performed under artificial conditions:

The second question is whether the test situation is so artificial as to have no meaning when the patient is not under supervision. To accomplish a standard test, the patient must be directed and urged to undertake the activity designated. The fact that he performs well in the test situation is no indication that he will continue to do so when he is away from the hospital or medical environment.[8]

Many patients who perform well in the hospital deteriorate on returning home. This reaction may be a response to the new environment or an advance in the physical or mental disturbance. The great majority of patients who will do poorly in the home can be identified while under treatment in the Department of Physical Medicine and Rehabilitation. Follow-up in the home is, of course, also necessary to assure continued optimal performance.

☐ Observer error, variations in patient's mood and breadth of test:

The scoring of any test will vary with the observer, the mood and medical situation of the patient. The development of a test to fit all types of disabilities and patients in all stages from comatose and incontinent to those with only a slight disability of several fingers or a hand is extremely difficult.

☐ Motivation:

"Motivation" is an important consideration in performance, even though no one knows what motivation is or how to measure it. Motivation will depend on the past experience of the patient with his family, friends and in the job, his emotional resources, as well as his goals and the possibility of fulfilling them in the future.

☐ Interdependence of activities:

Kelman and Willner[7] have pointed out some of the difficulties in the measurement and evaluation of performance. One of their important points is whether a single activity such as moving from a wheelchair to the toilet or dressing can be isolated from other activities of daily living as self-contained entities. The ability to dress will be of little use to the patient if he is unable to get out of bed or ambulate. The ability to move from wheelchair to the toilet is of little use if the patient has a colostomy. Ambulation is of little use if the patient is unable to dress himself. These are objections to an interval scale rather than to an ordinal scale.

☐ Variation in importance of specific activities to different patients:

The above criticisms suggest some of the difficulties in measuring activities of daily living. When we attempt to compare these activities in different patients, we fall into even deeper difficulties. For instance, step climbing for one patient may be of no particular significance in increasing his independence, but for another patient it may make all the difference between holding a job or being in an institution. How is it possible to compare in an individual the value of moving from bed to wheelchair with the value of ambulating? These are completely different categories and have little comparative value.

It is necessary, therefore, to have some estimate of the homogeneity of each diagnostic group under study. In the case of hip fracture there is evidence that patients with similar ADL scores have similar losses in specific functions such as walking, stair climbing, and wheelchair activities. Furthermore, patients with very high or very low scores tend to be deficient in the same activities.

☐ Initial ADL Score:

When patients are seen for initial evaluation, they may be making rapid strides toward recovery of function, related more to the natural history of the disease, improvement in orientation and mood than to any specific effect of rehabilitation techniques in the narrow sense of instruction in activities of daily living. Thus, incontinence of urine and feces, commonly found in bedfast disoriented patients with cerebral infarctions, tends to disappear as consciousness, orientation and mobilization improve. At about the same time the patient is ready to be seen in a Department of Physical Medicine and Rehabilitation, there can be expected to be an improvement in continence. Thus rehabilitation techniques frequently take advantage of the natural history of the disease in addition to, in themselves, bringing about improvement.

The initial ADL test is performed at a period when the patient may be rapidly improving, so that the time he is referred to the Department of Physical Medicine and Rehabilitation will influence the final decision as to how much he has improved. The earlier he is referred, the greater the improvement should be.

☐ Conclusions in Regard to the Use of the ADL Score for Measurement of Independence

● The ADL score has a high reliability correlation with two judges both for the total score and on inter-item correlation. ● It can be used in all types of patients. ● It is an ordinal scale which measures degree of independence. ● The total score gives a rough index of independence in all patients. ● When patients with the same disease

are compared, the total score gives a good index of relative independence. ● Serial changes in the total score give a good measure of changes in independence in the individual patient.

An attempt was made to analyze the relationship of ADL scores with "unskilled" nursing care. "Unskilled" nursing care was defined as all personal nursing care that can be performed by anyone other than a Registered Practical Nurse or Registered Nurse. On our wards this would exclude catheter care, administration of drugs and tracheal suction. Changing of beds, assisting patients in personal toilet, washing, dressing, getting in and out of bed are considered examples of "unskilled nursing care."

Nurses on five different wards in a chronic hospital were asked to select ten different patients who had been treated or were being treated in the Department of Physical Medicine and Rehabilitation. They were asked to list the patients in order of how much "unskilled" nursing care was required. No. 1 would require complete care; No. 10 would require little, if any.

An ADL test was then performed on each patient. The rank given by the nurses was compared with the ADL score rank. Table 1 shows that the Spearman Rank Correlation Coefficient was consistently around .85.

TABLE I

Spearman Ranking Correlation Coefficient (r_s) between ADL scores, and "unskilled" nursing needs.

	r_s
Ward 1	.85
Ward 2	.86
Ward 3	.86
Ward 4	.85
Ward 5	.85

Problems with the MSCL

This test identified deficits in orientation, memory, calculation, writing and naming of objects. The total score gives an estimate of how well the patient will be able to understand and cooperate. It cannot be used in patients who are deaf or dumb, or cannot understand English, but in general, it can be easily applied by non-technical personnel to nearly all patients.

Summary

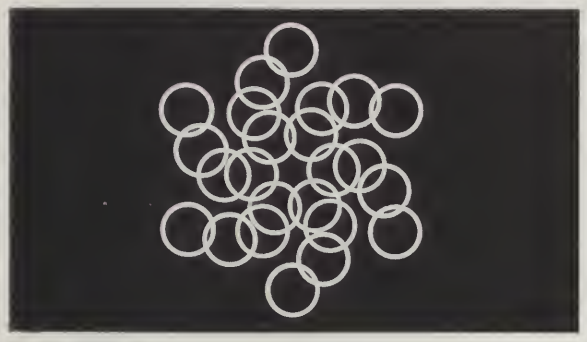
Once a diagnosis has been established, good medical management requires that the potential benefits of surgery, drugs, diet, rest, psychiatric therapy, physical therapy and rehabilitation be considered. With the increasing number of patients with multiple chronic diseases, it is important to identify and attempt to measure the factors which indicate the use of physical therapy and rehabilitation techniques. These methods should be so *simple, reliable* and *repeatable* as to allow their use by any physician, so *general* as to be applicable to any patient (irrespective of age, social, mental or diagnostic category) and so *precise* as to identify clearly those patients who will benefit from available techniques.

Based on a study of 3,148 patients with all types of chronic diseases and impairments referred to a Department of Physical Medicine and Rehabilitation, it has been possible to identify data, collected at initial evaluation, which are of importance in predicting the outcome of therapy. These data fall into three categories: the diagnosis, the physical performance (ADL) and the mental performance (MSCL). An attempt has been made to arrange these categories into ordinal scales which will be useful in generating more precise measuring instruments of predictive value in regard to the outcome of therapy. The meaning, methods, presuppositions and uses of measurement are presented.

The methods of measurement described herein were developed using patients with all types of chronic diseases and impairments in an attempt to produce a generalized method which will apply to any patient. "The whole purpose of general concepts is to make the distinctions between special classes clear."[9] Future articles will attempt to apply the method to patients with a single predominant disease, syndrome or impairment.

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From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

alcoholism section

Training Sessions on Treatment of Alcoholics

With passage of Maryland's Comprehensive Intoxication and Alcoholism Control Law, effective July 1, 1968, interest is rising among physicians and health personnel generally in preferential methods of treating the acute and chronic phases of alcoholism.

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Alcoholism and the Alcoholic

Time: Thursday, November 21, 1968, 9:00 A.M. - 4:00 P.M.
Place: Baltimore Student Union Bldg, 621 W. Lombard St.
Sponsor: Committee on Postgraduate Courses
University of Maryland School of Medicine

Introducing Alcoholism and the Alcoholic

Maxwell N. Weisman, MD, Director, Alcoholism Control Division, Department of Mental Hygiene

Didactic presentation
Interview with alcoholic patient
Open discussion

Treatment of Acute Alcoholic Detoxification and Withdrawal Syndrome

Roland T. Smoot, MD, Chief, Department of Medicine, Provident Hospital

Didactic presentation and open discussion

Early Detection and Office Treatment of the Alcoholic Patient

Marvin A. Block, MD, Chairman (1954-1964), AMA Committee on Alcoholism; Vice-President, National Council on Alcoholism, Inc.

Didactic presentation and open discussion

Treatment of Chronic Alcoholism

Panel Moderator: Isadore Tuerk, MD, Former Commissioner of Mental Hygiene 1960-68

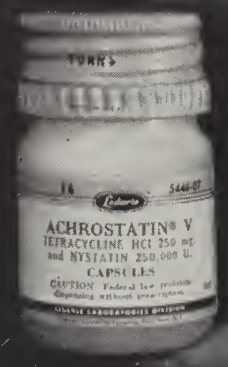
Panel Members: John H. Hirschfeld, MD (practicing internist), President, Baltimore Area Council on Alcoholism, Inc.

Mehdi Yeganeh, MD (psychiatrist), Director of Community Mental Health Services, Baltimore County Health Department

Panel presentation and open discussion

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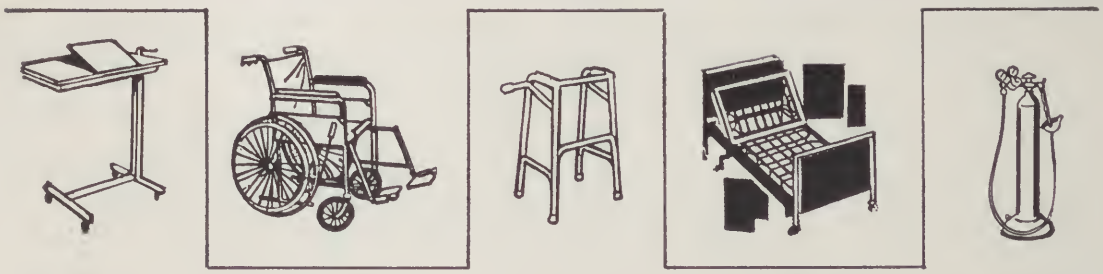


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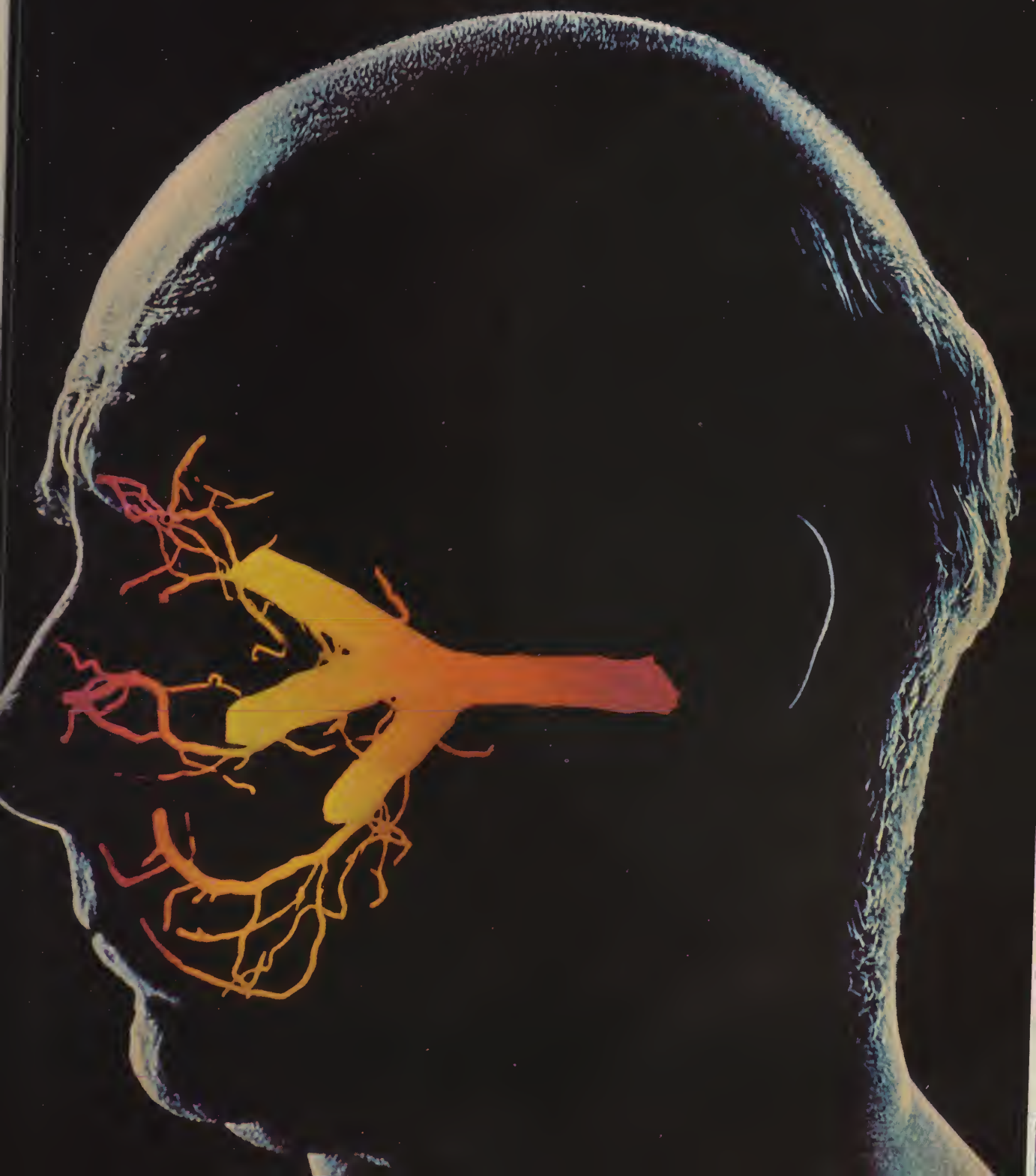
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Fatal cases of aplastic anemia have been reported following treatment with Tegretol. Agranulocytosis, thrombocytopenia and transitory leukopenia have also been observed.
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Indication Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia. It is not a simple analgesic and should never be administered for relief of trivial facial aches or pains.
Contraindication Do not use in those with a known sensitivity to any tricyclic compound or in those being treated with M.A.O.I. agents. As long a period as possible should elapse before using Tegretol in patients who have been treated with M.A.O.I.'s, with a minimum of 7 days. In such cases, initial dosage should be low and the patient's reaction to gradual increments closely observed.
Important Note and Precautions Familiarity with the clinical symptoms which lead to an accurate diagnosis of true trigeminal neuralgia and with the complete prescribing information, careful patient selection, a thorough examination before treatment and close patient supervision throughout the treatment period are essential to the safe and effective use of this drug.
Where feasible, Tegretol should not be used in conjunction with any potent drug which may increase the possibility of toxic reactions.
In pregnancy, the drug should not be prescribed during the first trimester and thereafter only to patients in whom the clinical situation warrants the potential risk. It should not be administered to nursing mothers.
Patients with increased intraocular pressure should be closely observed during treatment with this drug because of its anticholinergic effect.
Because of the drug's relationship to other tricyclic compounds, the possibility of activation of latent psychosis and, in the elderly, of confusion or agitation, should be considered.
Dizziness and drowsiness may occur and patients should be cautioned about the hazards of operating machinery or automobiles and of engaging in other hazardous tasks.
Use cautiously in patients with a history of coronary artery disease, organic heart disease, congestive failure or liver disease.
Before initiating therapy, the following laboratory procedures should be performed:
1. Complete blood and platelet counts which, if abnormal, should rule out the use of the drug.
2. Baseline evaluations of liver function.
During treatment with Tegretol, the following laboratory procedures should be performed:
1. Complete blood and platelet counts should be done at intervals of one week during the first month of drug treatment, every two weeks during the second and third months, and at monthly intervals thereafter for as long as the patient is taking the drug. A trend toward a decreasing white blood cell count should suggest a dosage reduction and more frequent laboratory and clinical evaluations. Should this trend continue, the dru should be discontinued.
2. Liver function tests must be performed at regular intervals during tre ment with this drug since liver damage may occur during therapy. The drug should be discontinued immediately in cases of aggravated liver dysfunction or active liver disease.
3. Periodic eye examinations, including slit-lamp, funduscopy and tonoe etry, are recommended for patients being treated with this drug since many phenothiazines and related drugs have been shown to cause eye changes.
4. Complete urinalysis and BUN should be done on patients treated w Tegretol because of observed renal dysfunction.
Adverse Reactions Dizziness, drowsiness, unsteadiness on the feet, nausea, vomiting, aplastic anemia, transitory leukopenia, agranulocyto eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormalities i liver function tests, cholestatic and hepatocellular jaundice, urinary fre quency, acute urinary retention, oliguria with elevated blood pressure, albuminuria, glycosuria, elevated BUN, microscopic deposits in the uri impotence, disturbances of coordination, confusion, headache, fatigue blurred vision, transient diplopia and oculomotor disturbances, speech disturbances, abnormal involuntary movements, peripheral neuritis an paresthesias, depression with agitation, talkativeness, nystagmus, tin- nitus, paralysis and other symptoms of cerebral arterial insufficiency, pruritic and erythematous rashes, urticaria, Stevens-Johnson syndrom photosensitivity reactions, alterations in skin pigmentation, exfoliative dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, eryt multiforme and nodosum, aggravation of disseminated lupus erythema tosus, gastric distress, abdominal pain, diarrhea, constipation, anorex dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills, adenopathy, lymphadenopathy, aching joints and muscles, leg cramps conjunctivitis, left ventricular failure, aggravation of hypertension, hyp tension, syncope and collapse, edema, aggravation of coronary artery disease and congestive heart failure. (Whether these cardiovascular e are drug-related is not known. However, some of these complications resulted in fatalities.) The necessity for discontinuing the drug should dictated by the gravity and severity of the adverse reactions.
Dosage and Administration The drug should always be taken with me if possible.
Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, the should be increased in one-half tablet (100 mg.) increments every 12 until freedom from pain is achieved. To relieve pain, between 200 mg 1200 mg. per 24 hours may be necessary.
Maintenance: Initial control of pain can be maintained in most patien with a dose of 400 mg. to 800 mg. daily. Maintenance doses may rang between 200 mg. and 1200 mg. daily.
At least once every 3 months during treatment period attempts shoul made to discontinue the drug or to reduce the dose to the minimum effective level.
Availability Round, white, single-scored tablets of 200 mg. In bottles of 100 and 1000. (B)46-820
For complete details, please see Prescribing Information.

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When you diagnose depression, Tofrānil may be indicated for relief.

As maintenance therapy during the active phase of depression, Tofrānil can often help prevent relapse.

The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated. In patients with cardiovascular disease, thyroid disorders, increased intraocular pressure; in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication or antihypertensive adrenergic neuron-blocking agents; and in those in their first trimester of pregnancy—the special precautions listed in the Prescribing Information should be carefully observed.

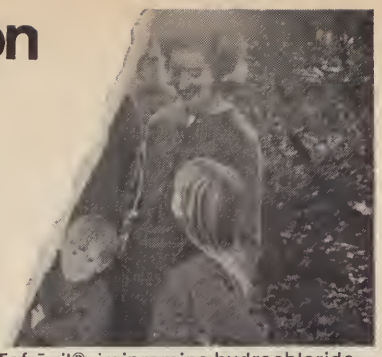
Toxic reactions severe enough to require discontinuation of Tofrānil are uncommon. However, for complete details, please refer to the complete Prescribing Information.

Turn page for brief summary of Prescribing Information.

Tofrānil® imipramine hydrochloride
Geigy

in depression





Tofrānil® Geigy

imipramine
hydrochloride

Tofrānil®, imipramine hydrochloride
Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be substituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, it should not be used during the first trimester of pregnancy. Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy. Because of its anticholinergic effect, caution should be observed in prescribing the drug for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when this compound was added to the regimen. Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 years of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (including hypomanic and manic episodes) which may require dosage reduction and/or addition of a tranquilizer or temporary discontinuation of the drug, epileptiform seizures, orthostatic hypotension and substantial blood pressure fall in hypertensive patients, purpura, transient jaundice, bone marrow depression including agranulocytosis, sensitization and skin rash including photosensitization, eosinophilia, and mild withdrawal symptoms on sudden discontinuation after prolonged treatment with high doses. Occasional hormonal effects (impotence, decreased libido, and estrogenic effects) may be observed. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those using anticholinergic agents (including antiparkinsonism drugs).
Outpatient Adult Dosage: Initially, 75 mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)R-46-850-C

For complete details, please refer to the full Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
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TO-6757

The Maryland Association of Medical Assistants

The semi-annual convention of the Maryland Association of Medical Assistants was held in Ocean City, Md. the week-end of September 7-8. The convention activities took place at the Ship's Café.

Following registration and a business meeting, **Louis Mould, MD,** of Cumberland, and **Miss Betty Schwartz,** Director of the Florence Crittendon Home for Unwed Mothers, were introduced as guest speakers for the afternoon.



Dr. Mould

Dr. Mould is a 1952 graduate of Queens University in Kingston, Ontario, Canada. He served his internship and assistant residency in Canada at the Kingston General Hospital and the Royal Victoria Hospital, Montreal, respectively. He divided his residency in obstetrics and gynecology at Baltimore City Hospitals and Mercy Hospital, Baltimore.

From 1956-57 Dr. Mould was instructor at the University of Maryland Medical School in obstetrics and gynecology.

In 1957 he moved to Cumberland. At present, he is on the staff of Memorial and Sacred Heart Hospital.

Highlighting the day's events was the banquet based on a Hawaiian theme. The invocation was given by the **Rev. Thomas Subock** of Annapolis, and **John F. Eyring, MD,** served as master of ceremonies.

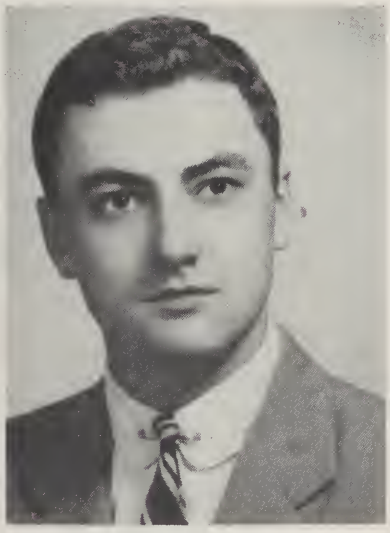
* * *

The members of MAMA have again voted to send Christmas packages to the fighting men in Viet Nam. **Mrs. Barbara Daniel,** chairman of the committee, requests that anyone wishing to contribute, please send contributions to her at Church Home & Hospital, c/o Physical Therapy Department, 100 N. Broadway, Baltimore 21231.

* * *

In order to sponsor MAMA's three delegates to the AAMA National Convention held in Columbus, Ohio, October 9-12, the association held a dance on September 28 in Lippens Hall.

Delegates who attended the 12th annual convention were **Mrs. Gertrude Gillum, president; Mrs. Dorothy Hartel, nominee for president-elect AAMA; and Mrs. Nell Chaney, past-president of MAMA.** Other Marylanders who attended the three-day meeting include **Mrs. Mabel Young,** Garrett-Allegany Chapter; and **Miss Sandra Orrinson,** Montgomery County Chapter.



Dr. Eyring



Summation:
In addition to its primary indications for duodenal and gastric ulcer, Robinul Forte (glycopyrrolate) is indicated for other G-I conditions that may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

Contraindications: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

Precautions: Administer with caution in the presence of incipient glaucoma.

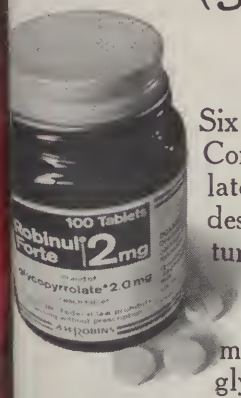
Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

Dosage: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day; in the a.m., early p.m., and at bedtime. See product literature for full prescribing information.

Supply: Robinul (glycopyrrolate 1 mg.): Robinul Forte (glycopyrrolate 2 mg.): Robinul-PH (glycopyrrolate 1 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming): Robinul-PH Forte (glycopyrrolate 2 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming), in bottles of 100 and 500 tablets. A. H. Robins Company, Richmond, Va. 23220.

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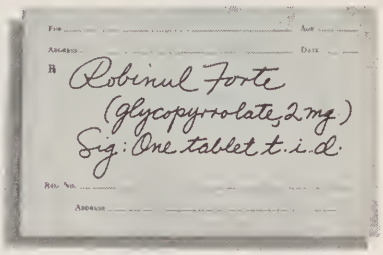
In peptic ulcer therapy, won't you give Robinul® Forte a Fair Trial?
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Six years ago the A. H. Robins Company introduced glycopyrrolate, a unique anticholinergic agent described in the prescribing literature as more closely approaching the ideal compound for controlling gastric hyperacidity and hypermotility of the G-I tract. Although glycopyrrolate (Robinul Forte) found good acceptance among numerous physicians, many others just didn't seem to want to give it a try, probably because the anticholinergic they were already using was giving acceptable results.

However, we believe you'll agree there's always room for a better anticholinergic. This is why we're asking you to give Robinul Forte a fair trial. Robinul Forte exerts a highly specific antisecretory action and a marked inhibitory effect on intestinal tone. We're convinced you'll agree that this is indeed an outstanding drug when you observe its outstanding suppression of ulcer symptoms. Furthermore, it is unique in that it reduces intestinal tone, yet has little or no effect on peristalsis. In addition, the incidence of the more bothersome peripheral side effects is low.

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First: When you see your very next ulcer patient, write him a script as shown.

Next: Wait 10 days or until your patient comes in for his next appointment and get his "verdict" as to how he feels. Examine all the evidence and make your evaluation of his condition.



Finally: Render **your** verdict. If it's "significant improvement and marked relief of symptoms," then we believe you'll agree that Robinul Forte has proved its worth, and we rest our case. If not, consider our case for Robinul Forte closed. That's a Fair Trial, Doctor, and it's all we ask.

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The summation is an important part of every case. You'll find ours on the preceding page, Doctor.





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ARTHUR E. COCCO, MD
Journal Representative

Baltimore City Medical Society

MEETING NOTES

The meeting of the Board of Directors held August 13, 1968 was called to order by the President, D. Frank Kaltreider, MD, at 4:30 P.M.

After the preliminary business of adopting the minutes of the May 14, 1968 meeting of the Board, the members were informed of the necessity of employing additional secretarial staff for the Baltimore City Medical Society office. Mrs. Dolores Janos, a long-time member of the Staff resigned on June 15, 1968 and the Board agreed that any additional secretarial help should be appointed at the discretion of the senior member of the staff, with budgetary requirements set forth by the Board.

Arrangements for a pension for Mrs. Lucie Maguire were approved by the Board and were acceptable to Mrs. Maguire as evidenced by a letter of appreciation from her. A letter of commendation to Mrs. Maguire for her devoted and loyal services to the Society had been prepared by Robert B. Goldstein, MD, and was signed by each member of the Board.

In response to a letter from the AMA suggesting participation in Community Health Week to be held this year from October 20 to 26, the Board decided that this activity should be left to the discretion of the Committee on Public Medical Education and Public Relations.

All future complaints received by the Professional Relations Committee of the Baltimore City Medical Society concerning anesthesiologists will be referred to the Judicial Committee of the Maryland-D. C. Society of Anesthesiologists. This action was the result of correspondence between Dr. Kaltreider and Joseph S. Redding, MD, President of the Maryland-D. C. Society of Anesthesiologists, in which it was agreed that this was a most appropriate and acceptable mechanism for handling such complaints.

A list of physicians in Baltimore City divided by census tracts has been provided by the Baltimore City Health Department to the Medical Society office. In the future, all requests from individuals for names of physicians in their area will be answered by the Baltimore City Medical Society office. This was formerly done by the Medical and Chirurgical Faculty staff.

The Board approved a letter sent to Governor Agnew regarding the recent cutback in funds for the Medicaid Program. Copies of the letter, which read as follows, were sent to local newspapers and TV stations for publication.

> Dear Governor Agnew:
>
> The reticence with which I address you is exemplified by the delay in again questioning your decision concerning the Medicaid Program. It seems unfortunate to us, the Baltimore City Medical Society, that the health of the medically indigent ranks so low in your allocation of the millions of dollars under your executive control. It is incongruous that the hospitals have received your wrath for their mounting costs and in return you are asking them (and the medical profession) to take care of the medically indigent without recompense, thereby, increasing the costs of medical care in hospitals still further.
>
> Would you please reconsider? We believe that the health of the medically indigent is more important than, for instance, roads.

John Collins Harvey, MD, informed the Board that a meeting of the Medical Care Committee with William J. Peeples, MD, Commissioner of the State Health Department and members of his staff was concluded with equitable agreements having been reached. The meeting was held to discuss the various reporting forms for the Medicaid Program and the availability of information concerning the Medicaid Program to proper authorities.

The Community Chest/Red Cross United Appeal program is progressing satisfactorily. The membership is reminded that pledge cards are being mailed to each member which they are asked to complete and return. The purpose of this mailing is not to query the amount contributed, but to poll physicians in order to obtain a count of the number of physicians participating in the campaign. It is hoped that the pledge card response will demonstrate to the United Appeal that physician participation is evident. After a reasonable period of time, the Woman's Auxiliary will undertake telephoning those individuals who do not reply, urging them to return the pledge card.

The report of the Medical and Chirurgical Faculty Policy & Planning Committee meeting held May 23, 1968 was distributed for information. This report is on file in the Baltimore City Medical Society office.

Raymond C. V. Robinson, MD, reminded the Board that under the present Medical Practice Act, podiatrists are allowed to prescribe medical and surgical treatment of the foot. This allows podiatrists to use systemic medications at their discretion. In some cases, podiatrists are prescribing drugs without adequate knowledge of the total medical disposition of the patient, a practice which could be disastrous. After some discussion, Dr. Robinson was appointed to write a resolution to be presented to the Med-Chi House of Delegates with the ultimate goal of changing the Medical Practice Act.

A letter of resignation from Harry J. Connolly, MD, a long-time member of the Baltimore City Medical Society, a Past-President, and member of the Board of Directors, was reluctantly accepted. Dr. Connolly's resignation was due to the recent relocation of his office outside the limits of Baltimore City.

The Board turned down a request from the Medical Committee for Human Rights which proposed support for a demonstration planned at Friendship Airport upon the return of Governor Agnew decrying his apparent inattention to the medical needs of the indigent as shown by his cutback in funds for the Medicaid Program. The Board felt that although it does not condone the action of the Governor in this matter, it would continue to use more reasonable approaches of showing displeasure than suggested by the Committee.

Dr. Kaltreider reported that he had been appointed to the Mayor's Health Services Advisory & Planning Council chaired by Francis X. Gallagher, Esq.

Some discussion was held concerning the report of the Med-Chi Bylaws Committee concerning the proposed change in the composition of the Faculty Council. The proposal states that each district would have one representative plus one additional representative for each 200 members of the component societies in that district. Under the present arrangement the central district, which includes Baltimore City, has eleven members and the proposal would decrease the number to ten. However, this would still not be an equitable distribution of representatives per percentage of membership. As this report is not to be recommended for approval at the upcoming meeting of the House of Delegates no action was deemed necessary by the Board at this time.

Emeritus Membership was approved for John A. Askin, MD, who has recently retired from active practice.

A plan for a specially equipped and staffed cardiac ambulance was presented in a letter from Gustav C. Voigt, MD. This plan is being funded through the Regional Medical Program and will operate in the eastern section of the City and possibly in Baltimore County. The base of operations will be at Baltimore City Hospitals. The proposal states that the ambulance will be specially equipped to care for coronary patients and will be accompanied by a member of the medical staff of City Hospitals. A program of education of the physicians practicing in the operations area is also proposed for proper utilization of the service.

The Board approved the program with the suggestion that a committee be set up among the practicing physicians in the area and the operators of the program and that this committee should meet four times each year. Such a committee would tend to encourage the cooperation of the physicians in the community by allowing a mechanism for resolving problems likely to arise.

The meeting was adjourned at 6:00 P.M.

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Friday, November 1, 1968, 8:30 PM

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Simon H. Carter, Jr., MD
President
Monumental City Medical Society

D. Frank Kaltreider, MD
President
Baltimore City Medical Society

PRIVATE PRACTICE OF MEDICINE
H. Garland Chissell, MD
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Caution: With use of DIA-quel Liquid observe the usual precautions associated with opium derivatives and anticholinergics.

Dosage: Usual adult dosage: 1 or 2 tablespoonfuls (15 or 30 ml.) t.i.d. or q.i.d. Usual children's dosage (Clark's rule): ½ to 2 teaspoonfuls (2.5 to 10 ml.) t.i.d. or q.i.d.

How Supplied: In 4 fl. oz. (118 ml.) band-sealed bottles.

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Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

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Carroll County Medical Society

The Carroll County Medical Society met September 4, 1968 at the Springfield State Hospital. Our Society is presently active in the following Public Relations projects: 1) The Family Doctor Program in which physicians discuss items of health and education over the local radio station, WTTR. These programs are broadcast three times a week, the average length is five minutes. 2) The Society, in cooperation with the Carroll County General Hospital medical staff and board of directors, is sponsoring a program to recruit additional physicians for the county. 3) At the Carroll County Farm Museum we are developing an exhibit of a family doctor's office of the 1850 era. Furnishings of that era are being sought by the Society and anyone having any information of the whereabouts of old furniture that could be useful to such an exhibit, is requested to pass the information along to the Society.

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in osteoarthritic pain

If aspirin doesn't help, move in with Tandearil.

The trial period is brief: 1 week. Try one tablet q.i.d. at first. Tandearil usually starts working within 3 to 4 days. When response occurs, as little as 1 or 2 tablets daily may hold back pain and stiffness, and increase joint motion.

On the next page is a summary of adverse reactions, contraindications, warning and precautions.

Tandearil.
It can help get his mind off his knee.

Please review full Prescribing Information carefully before prescribing.

For osteoarthritic knees, spines, shoulders, hips, etc.:

Tandearil®
oxyphenbutazone

Tandearil, oxyphenbutazone:
For brief summary see next page.

Geigy

7A-6006



Tandearil®
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

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Parents' Fears About Contact Sports Discussed in New Pamphlet

Many of the fears parents have about allowing their sons to participate in contact sports are discussed in a new AMA pamphlet, "Johnny Makes the Team."

The one-page pamphlet reminds parents of youth's desire for the thrill and adventure found in athletics and encourages them to assist schools to make athletics a powerful educational force.

"Parents are potentially the strongest force in determining school athletic policies," it says. "They should make certain that sports are conducted chiefly for the good of the players and that a physician is in attendance at all contests."

The pamphlet stresses the importance of protecting a child's health. If a child has been ill or injured, a doctor's permit should be secured before the boy returns to practice or competition.

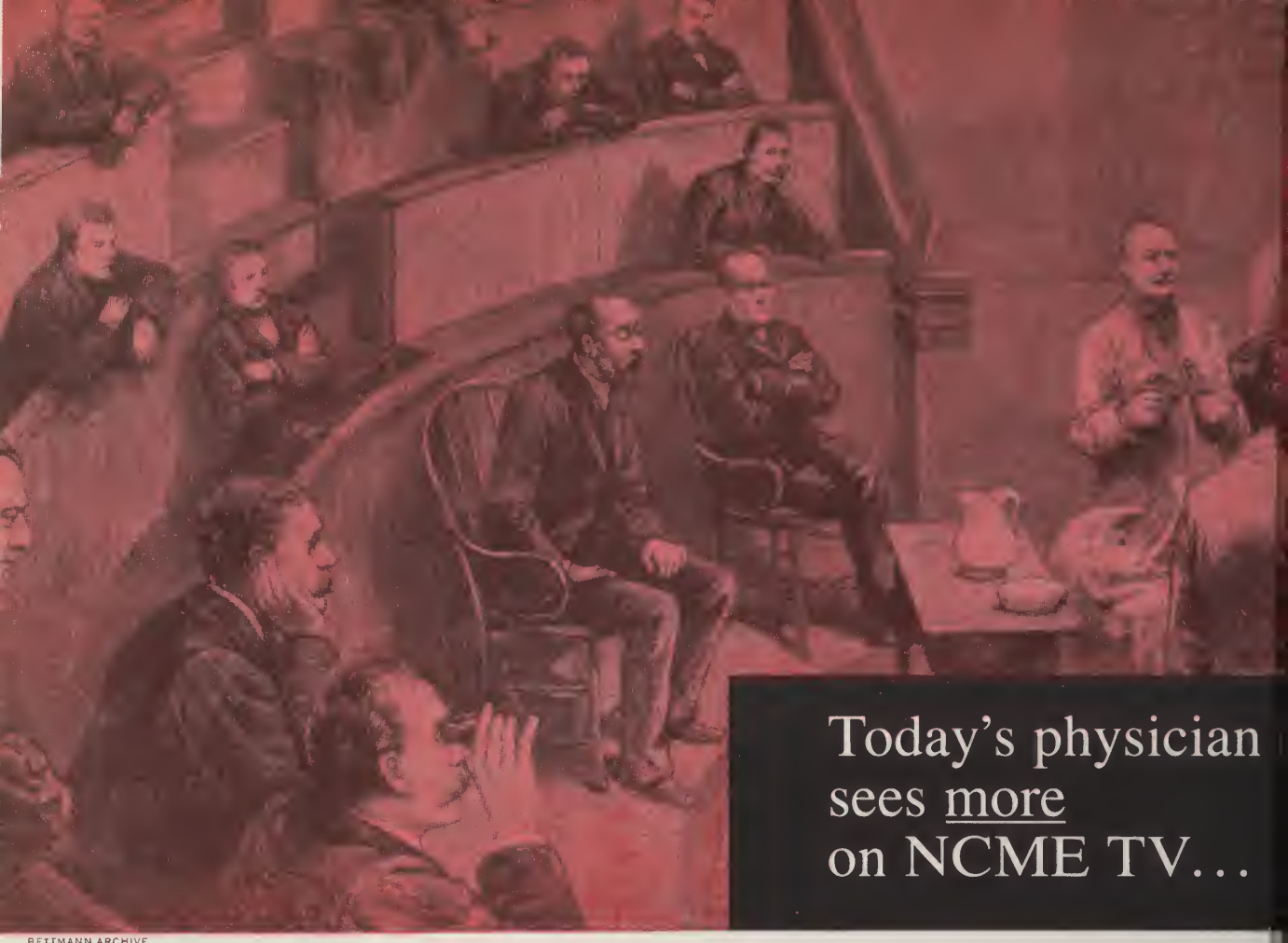
"As a parent you can be a dynamic factor in helping to make sound athletic policies stick, so that your boy's participation on his high school team will be one of the more profitable of his high school experiences," the pamphlet points out.

Review copies may be obtained from the AMA's Department of Health Education, 535 North Dearborn St., Chicago, Ill. 60610. Quantity copies are available from the Order Department at 10¢ each; 50–99, 9¢ each; 100–499, 8¢ each; 500–999, 6¢ each; 1,000 or more, 4¢ each.

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☐ To help your institution make effective use of closed-circuit television, NCME offers a wide range of services and utilization aids, including: Technical consultation in setting up a closed-circuit system; advance program information on the contents of each telecast; display units to help publicize programs; expense-paid seminars to improve utilization of medical television.

☐ NCME programs are brief and may be shown as often as desired; you can view the telecasts at times that are most convenient, without disrupting your normal schedule.

☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

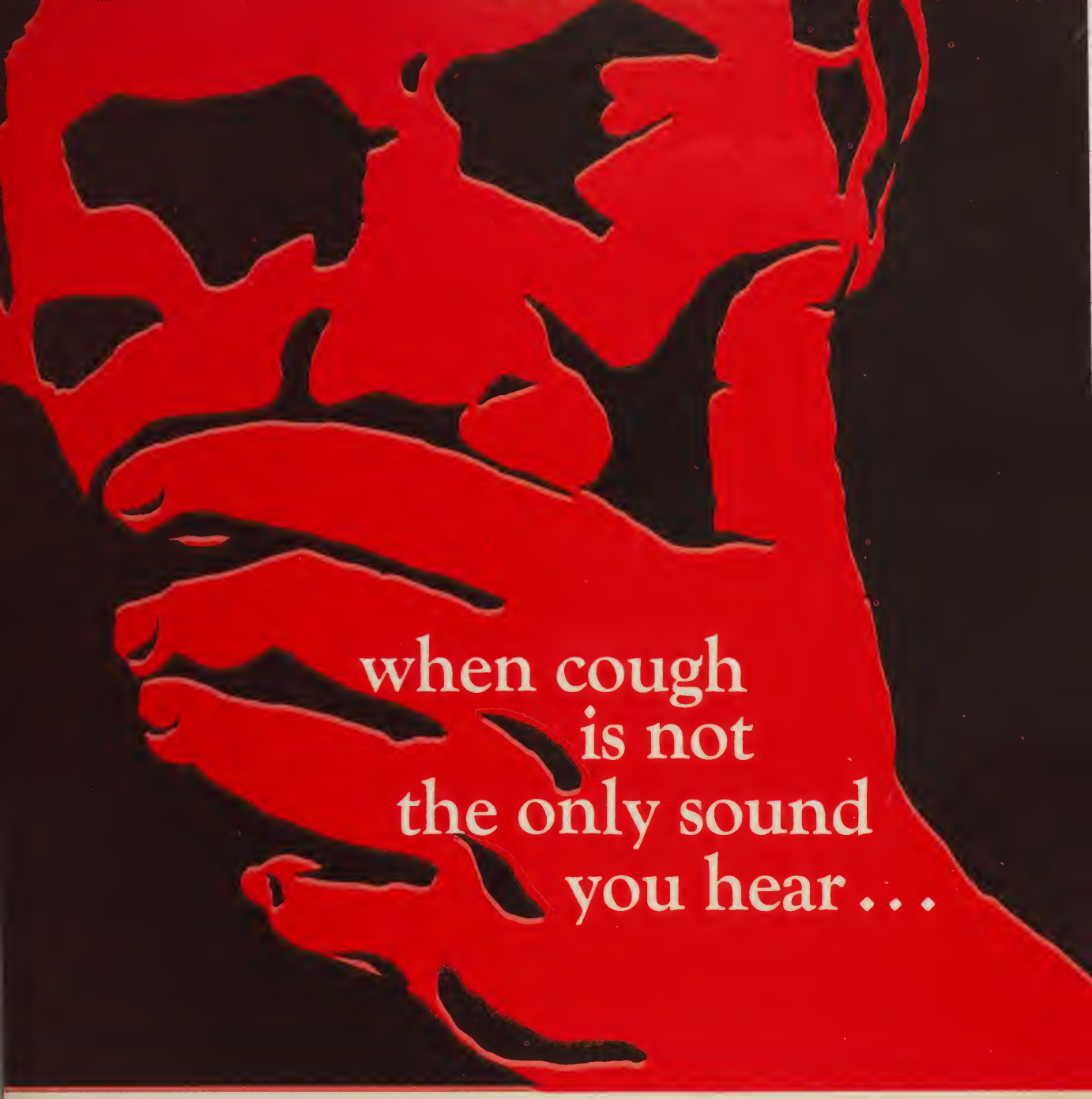
A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

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Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

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In the complex picture of moderate to severe anxiety...



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effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

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Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

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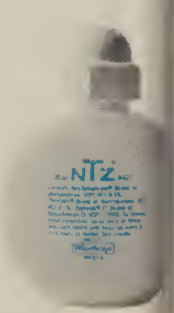
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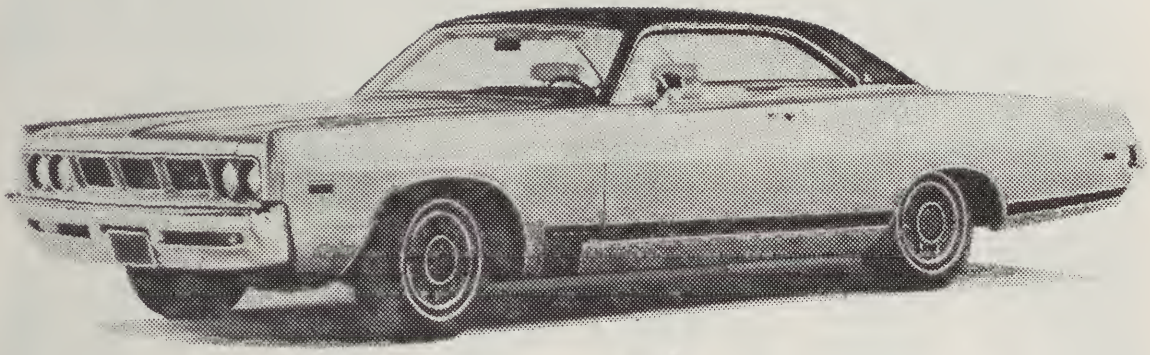
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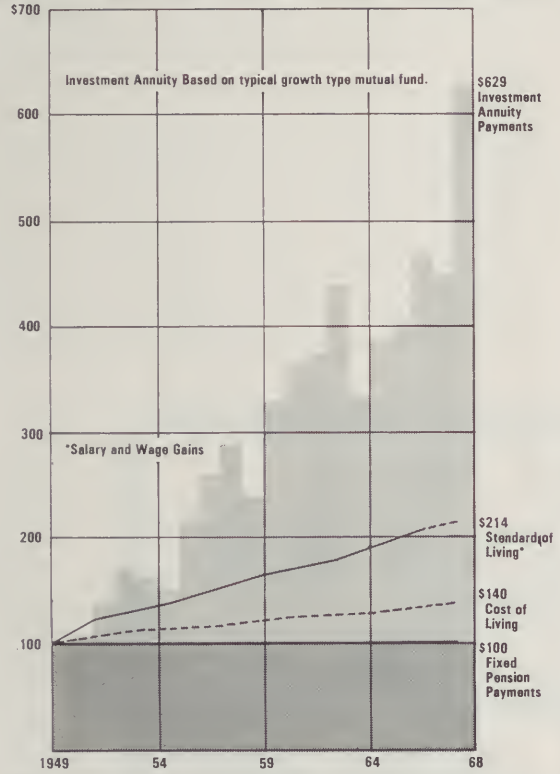
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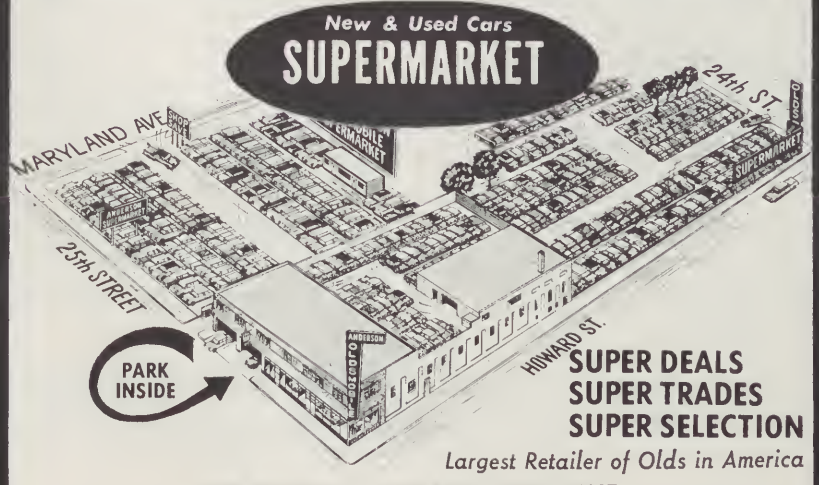
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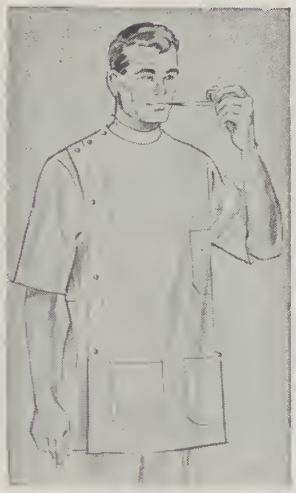
New York Compulsory Health Insurance

On March 20, Gov. Rockefeller submitted his proposed Compulsory Health Insurance Law to the New York Legislature. Employers of one or more persons would be required to provide employees and their dependents with 120 days of semi-private in-hospital care, including maternity, psychiatric care and ancillary hospital services, 100 days of home care, hospital outpatient diagnostic services, and hospital outpatient care for accidental injury or emergency illness. It provides for state contribution to the cost of required health benefits when the combined contribution of the employer and the employee exceeds 4% of the employer's annual payroll. These payments would be made upon application by the insurance carrier involved, following a review of the carrier's underwriting and other practices, and after consideration of coverage available elsewhere at lower premium costs. It would exempt insurers from the present tax on premiums for that coverage mandated by the bill.

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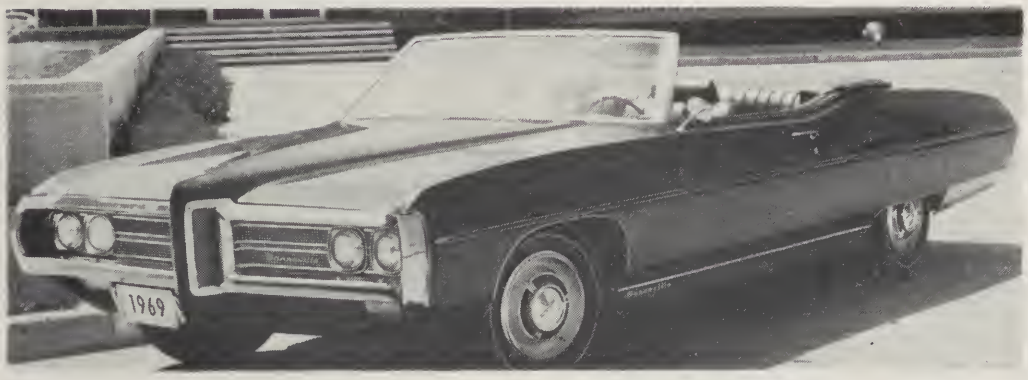
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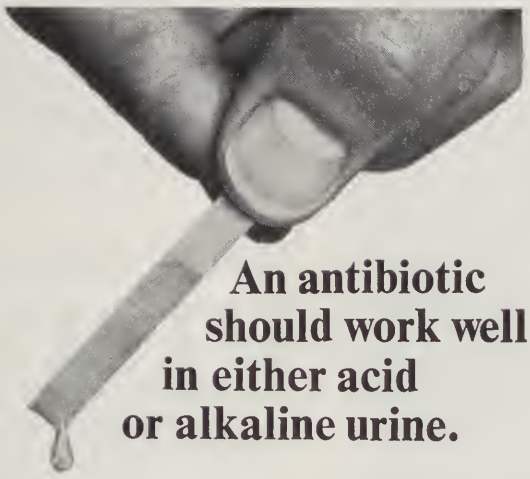
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J. Sheldon Eastland, MD—1970
Robert vL. Campbell, MD—1971

ALTERNATES:
M. McKendree Boyer, MD—1969
Robert C. Kimberly—1970
Charles F. O'Donnell, MD—1971
Terms of office expire at end of calendar year



An antibiotic should work well in either acid or alkaline urine.

It isn't always necessary to adjust urinary pH in treating G.U. infections.

Not when the causative organism is a strain sensitive to DECLOMYCIN® Demethylchlortetracycline, as is often the case.

DECLOMYCIN remains stable and active in either acid or alkaline urine. So there's no need to acidify the urine to keep the antibiotic at work.

Why match the urine to the antibiotic...when you can match the antibiotic to the urine...by prescribing DECLOMYCIN. A b.i.d. dosage makes therapy convenient for your patient.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system – anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin – maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney – rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions–urticaria, angioneurotic edema, anaphylaxis. Teeth – dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; Tablets: film coated – 300 mg, 150 mg and 75 mg of demethylchlortetracycline HCl.

355-8

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

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Is it depression?

He says "It's my stomach..."

...but his other symptoms: functional somatic complaints, anxiety, insomnia, anorexia, feelings of guilt strongly suggest an underlying depression.

when the diagnosis is depression

ELAVIL® HCl (AMITRIPTYLINE HCl | MSD)

Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.

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WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

Doctors take note...

NOVEMBER 18-22, 1968
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Stress and Disease: The Relationship of Psychologic and Social Forces in Pathogenic Mechanisms: University of Oklahoma Medical Center, Oklahoma City, Okla. Director: James F. Hammarsten, MD, FACP. Co-Directors: Robert A. Schneider, MD, W. O. Smith, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

NOVEMBER 19, 1968
HEART ASSOCIATION OF MARYLAND/MARYLAND HEART CHAPTERS

Meeting—Executive Board, Heart Assn. of Western Maryland: 6:30 PM. Contact: Heart Association of Maryland, 415 North Charles Street, Baltimore, Md. 21201.

NOVEMBER 19-20, 1968
AMERICAN HEART ASSOCIATION/COUNCIL ON ARTERIOSCLEROSIS

Annual Meeting: Balmoral Hotel, Bal Harbour, Florida. Open to all interested physicians and scientists. Contact: Maryland Heart Association, 415 North Charles Street, Baltimore, Md. 21201.

NOVEMBER 19-26, 1968
HEART ASSOCIATION OF MARYLAND/MARYLAND HEART CHAPTERS

Meeting—AHA annual meeting: Bal Harbor, Florida. Contact: Heart Association of Maryland.

NOVEMBER 20, 1968
AMERICAN HEART ASSOCIATION/COUNCIL ON CIRCULATION

Postgraduate Seminar—Neural and Humoral Mechanisms of Peripheral Vasodilatation: American Hotel, Bal Harbour, Fla. Open to physicians and scientists. Advance registration necessary. Contact: Alfred M. Bennett, MD, AHA, 44 E. 23rd Street, New York, N.Y. 10010.

NOVEMBER 20, 1968
AMERICAN HEART ASSOCIATION/COUNCIL ON RHEUMATIC FEVER AND CONGENITAL HEART DISEASE

Postgraduate Seminar—Cardiovascular Problems of the Adolescent and Young Adult with Congenital Heart Disease: Americana Hotel, Bal Harbour, Fla. Open to physicians and scientists. Advance registration necessary. Contact: Alfred M. Bennett, MD, AHA, 44 E. 23rd Street, New York, N.Y. 10010.

NOVEMBER 20, 1968
AMERICAN HEART ASSOCIATION/COUNCIL FOR HIGH BLOOD PRESSURE RESEARCH

Postgraduate Seminar—Antihypertensive Drug Therapy: Americana Hotel, Bal Harbour, Fla. Open to physicians and scientists. Advance registration necessary. Contact: Alfred M. Bennett, MD, AHA, 44 E. 23rd Street, New York, N.Y. 10010.

NOVEMBER 20, 1968
AMERICAN HEART ASSOCIATION/COUNCIL ON CARDIOVASCULAR SURGERY

Postgraduate Seminar—Cardiac Transplantation and Myocardial Revascularization: Americana Hotel, Bal Harbour, Fla. Advance registration necessary. Contact: Alfred M. Bennett, MD, AHA, 44 E. 23rd Street, New York, N.Y. 10010.

NOVEMBER 20, 1968
AMERICAN HEART ASSOCIATION/COUNCIL ON BASIC SCIENCE/NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

Postgraduate Seminar—Cardiovascular Mechanics: Definition of Terminology and Problems—A Report on 1968 Summer Workshop: Americana Hotel, Bal Harbour, Fla. Advance registration necessary. Contact: Alfred M. Bennett, MD, AHA, 44 E. 23rd Street, New York, N.Y. 10010.

NOVEMBER 20-22, 1968
NATIONAL SOCIETY FOR THE PREVENTION OF BLINDNESS, INC.

Conference—Latest Developments in Detecting and Combating Potentially-Blinding Eye Diseases, Community-Action Eye Health Programs, and Programs for Industrial and School Eye Safety: Roosevelt Hotel, New York, N.Y. Contact: National Society for the Prevention of Blindness, Inc., 79 Madison Avenue, New York, N.Y. 10016.

NOVEMBER 22-23, 1968
HAHNEMANN MEDICAL COLLEGE AND HOSPITAL

Postgraduate Course—Psychedelic Drugs: Marriott Motor Hotel, Philadelphia, Pa. Director: Paul Jay Fink, MD. Contact: Sage Rosen, Assistant Director, Postgraduate Education, Hahnemann Medical College and Hospital, Department of Medicine, 230 N. Broad St., Philadelphia, Pa. 19102.

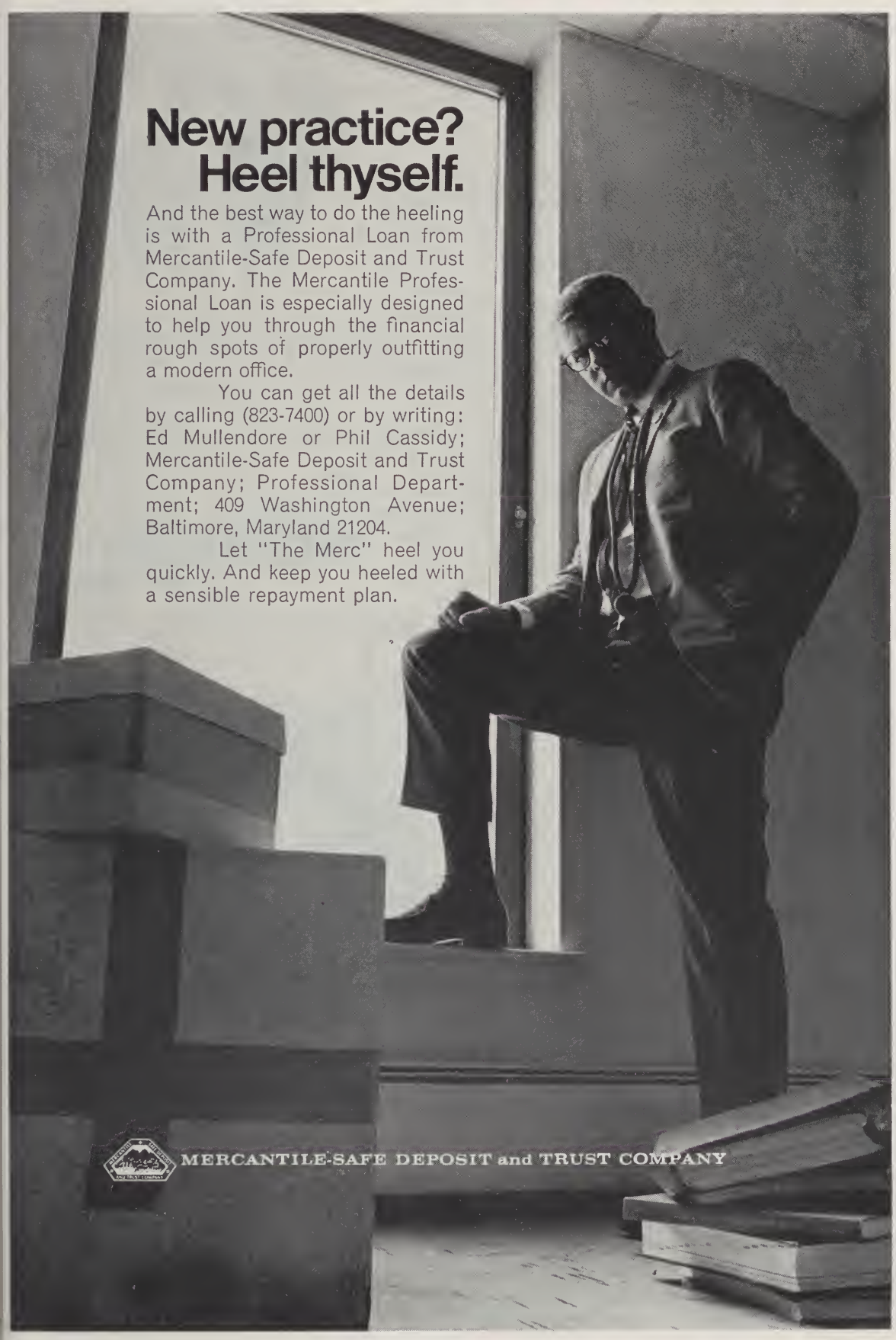
DECEMBER 1, 1968
AMERICAN MEDICAL ASSOCIATION

Conference—Medical Aspects of Sports: Hotel Deauville, Miami Beach, Florida. Open to key non-medical athletic personnel as well as physicians. Contact: Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn Street, Chicago, Ill. 60610.

In Future Issues of the JOURNAL

Watch for—

- Med-Chi's Annual Meeting Previews
- The Trauma Section
- A Traffic Safety Page


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Mano Swartz

executive secretary's newsletter

November, 1968

RESOLUTION DEADLINE DATE

Resolutions for consideration at the Faculty's Annual Meeting, April 11, 1969, must be received in the Faculty office prior to FRIDAY, FEBRUARY 14, 1969. Article XI, Section 23, of the Faculty's Bylaws stipulates this requirement for resolutions submitted by other than members of the Faculty's Council or Committees.

HIGHER PROFESSIONAL LIABILITY RATES

Higher Professional Liability Rates went into effect in October, 1968, for most States. The rates apply to members of the Insurance Rating Board, an industry organization whose members include many major stock insurance companies. The Article citing this appeared in the Wall Street Journal of October 11, 1968.

Maryland was quoted as having a rate boost of 55% over previous insurance premium rates. The Faculty-sponsored program, however, made only slight adjustments in its premium structure.

And for those who believe any adjustment is too high, attention might be directed to Los Angeles, California, where a general surgeon pays a standard rate of $1,688. per year for a policy providing $300,000/$900,000 coverage.

NEW DIRECTORY AVAILABLE

The Faculty's 1968/69 Directory finally came off the press in mid-October. Changes incorporated into the new issue include a listing of all general hospitals in Maryland, together with the names of their administrators and chiefs of service.

All Faculty members received a copy free. Additional copies are available at $5.00 per copy, plus 55¢ postage.

"MODEL" ACT

A "model" Act to provide for Incorporation of Self-Employed Persons has been developed by the Faculty and is available to members who would like to receive a copy. Present plans are for this to be introduced at the 1969 General Assembly for possible enactment at that time.

CONSUMER CREDIT COUNSELING

The Consumer Credit Counseling Service of Greater Baltimore, Inc., is a non-profit organization that was formed following passage of legislation by the Baltimore City Council outlawing professional debt management groups. Its original financing was underwritten by the major department stores, finance companies and other groups, who organized the service at the request of the Mayor of Baltimore City.

Recently, a major policy decision was made by its Board of Directors - all volunteers who serve without pay. This decision established that those persons receiving payments on long outstanding accounts would have 15% deducted from the total to help underwrite the expenses of the operation of the service.

In most cases, these are accounts that have either been written off by the physician or on which payment has never been made. If the same accounts were turned over to a collection agency, a figure of 20-50% would be taken by the agency for the services it performs.

Since the organization's inception in 1967, a total of $6,513.41 has been turned over to physicians; nearly $3,300.00 of it during the first nine months of 1968.

FRANKLIN SQUARE HOSPITAL SURVEY

Franklin Square Hospital is undertaking a survey of all physicians in the 11th, 12th, 14th and 15th election districts in Baltimore County. More than 75 physicians will be interviewed during the next few months to obtain an "in-depth" profile of the medical services now available, as well as to determine what medical services are desired by area physicians.

The survey will include questions on office hours, educational programs, consultation services, referral patterns, hospital affiliations, as well as other areas. It is anticipated that the study will help prevent duplication of services and assist in the proper development of adequate staffing and teaching programs. It is being supported by the Hospital and the Maryland Regional Medical Program.

John Sargeant

Executive Secretary

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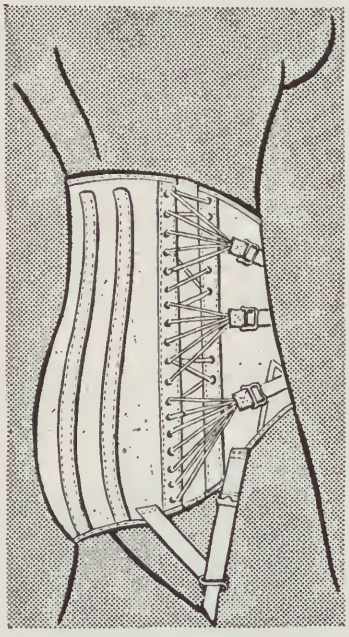
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TETRACYCLINE

Contraindications: Hypersensitivity to tetracycline.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Side Effects: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

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uspected tetracycline-sensitive infection?

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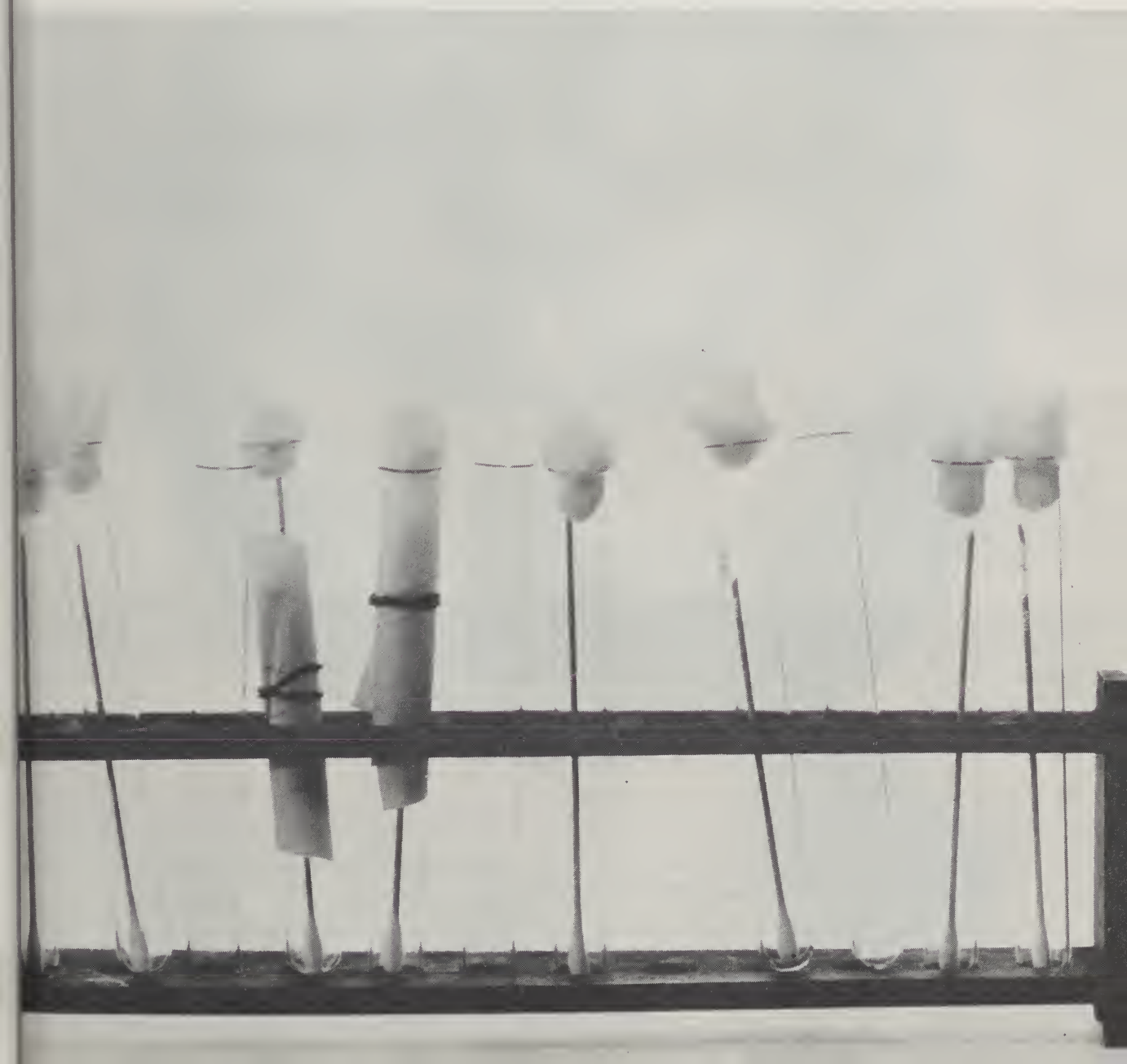
lthough of course it can't replace routine nsitivity testing, your prescription for CHROMYCIN® V, in a way, provides the timate test of therapy under rigorous *in vivo* nditions.

Because ACHROMYCIN® V is effective in eating so many common infections—caused by rains of tetracycline-sensitive organisms—oesn't *stat* dosage of this time-tested antibiotic ake good sense?

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Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
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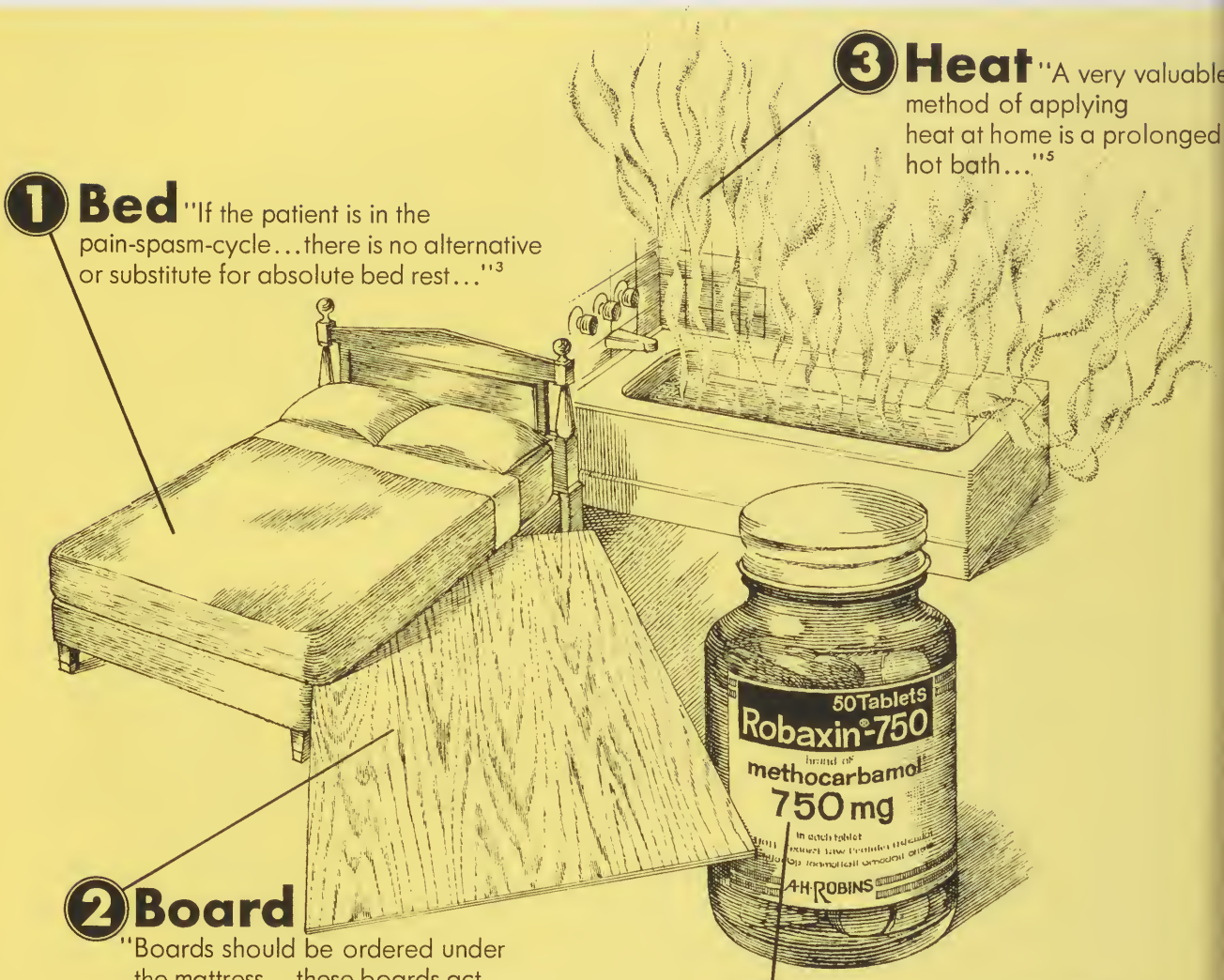
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1 Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

2 Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

3 Heat "A very valuable method of applying heat at home is a prolonged hot bath..."[5]

4 Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."[7] And there is little likelihood of sedation.[6]

Indicated for relief of skeletal muscle spasm. **Contraindicated** in hypersensitive patients. **Side Effects** (lightheadedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently. See product literature for further details. **Also available:** Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.)

References: (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gottschalk, L.A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cozen, L.: South Dakota J. Med. 18:26, 1965. (5). Soto-Hall, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

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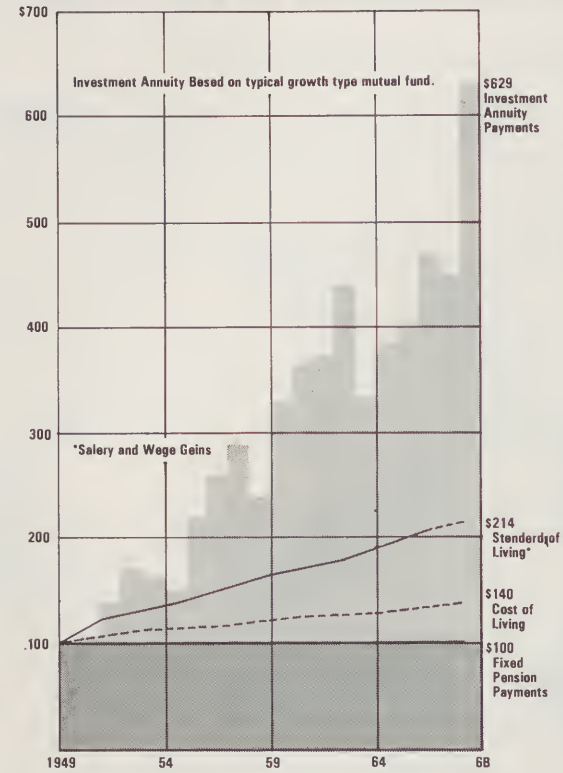
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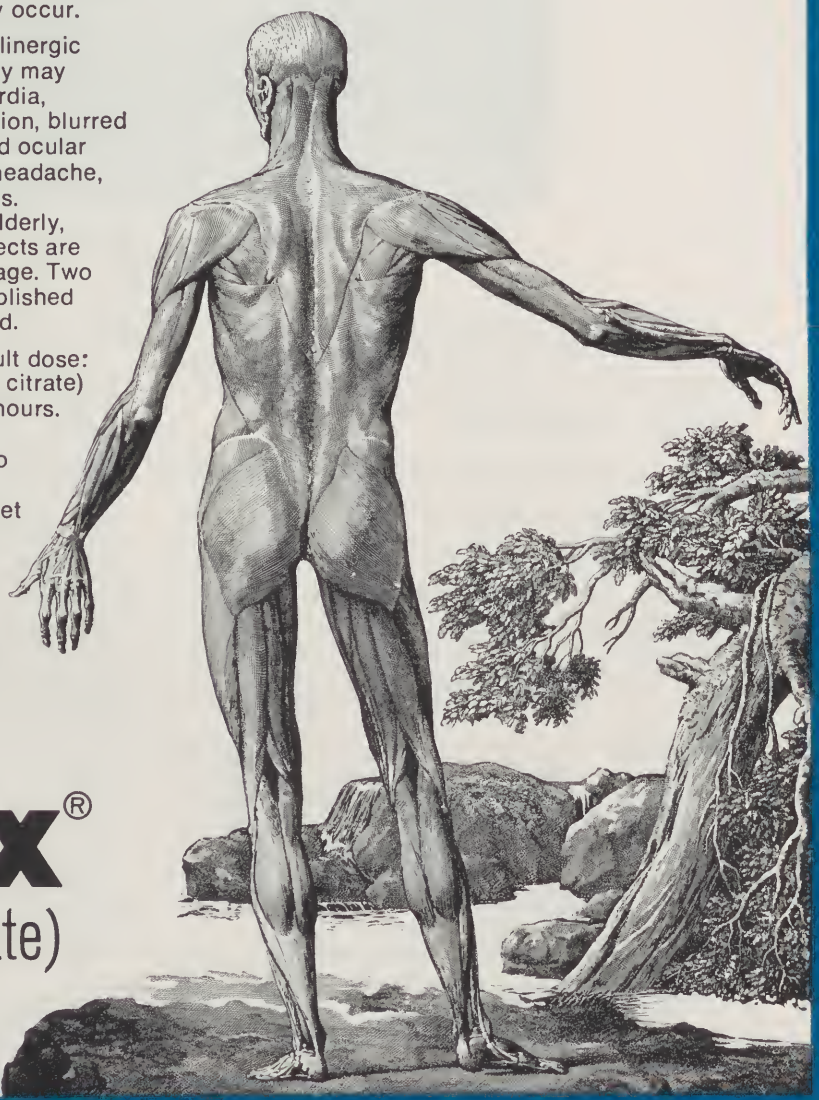
WARNING: Transient lightheadedness or dizziness following NORFLEX-INJECTABLE may occur.

SIDE EFFECTS: Due mainly to anticholinergic action and usually at high dosage. They may include dryness of the mouth, tachycardia, palpitation, urinary hesitancy or retention, blurred vision, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, and drowsiness. Infrequently, mental confusion in the elderly, urticaria or other dermatoses. Side effects are usually eliminated by reduction in dosage. Two cases of aplastic anemia, with no established causal relationship, have been reported.

DOSAGE: **INJECTABLE** — Average adult dose: one ampul, 2 cc. (60 mg. orphenadrine citrate) I.M. or I.V. May be repeated every 12 hours. Relief may be maintained with one NORFLEX tablet b.i.d. **TABLETS** — Two tablets per day for adults, one in the morning, one in the evening. Each tablet contains 100 mg. orphenadrine citrate.

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(tetracycline phosphate complex-nystatin)

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PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles. **A. H. F. S. Category 8:12**

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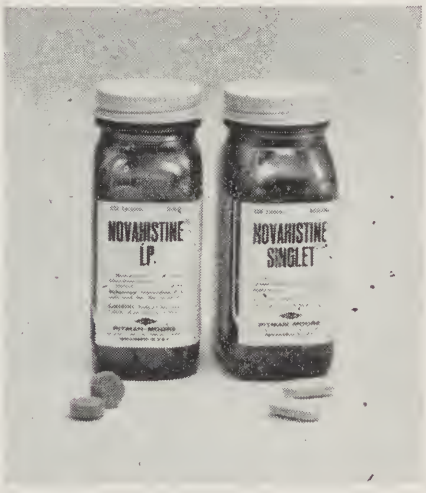
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Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

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Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.



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the "Action" gap

Of the more than 100 different types of cancer, colon and rectal cancers are unique for two compelling reasons:

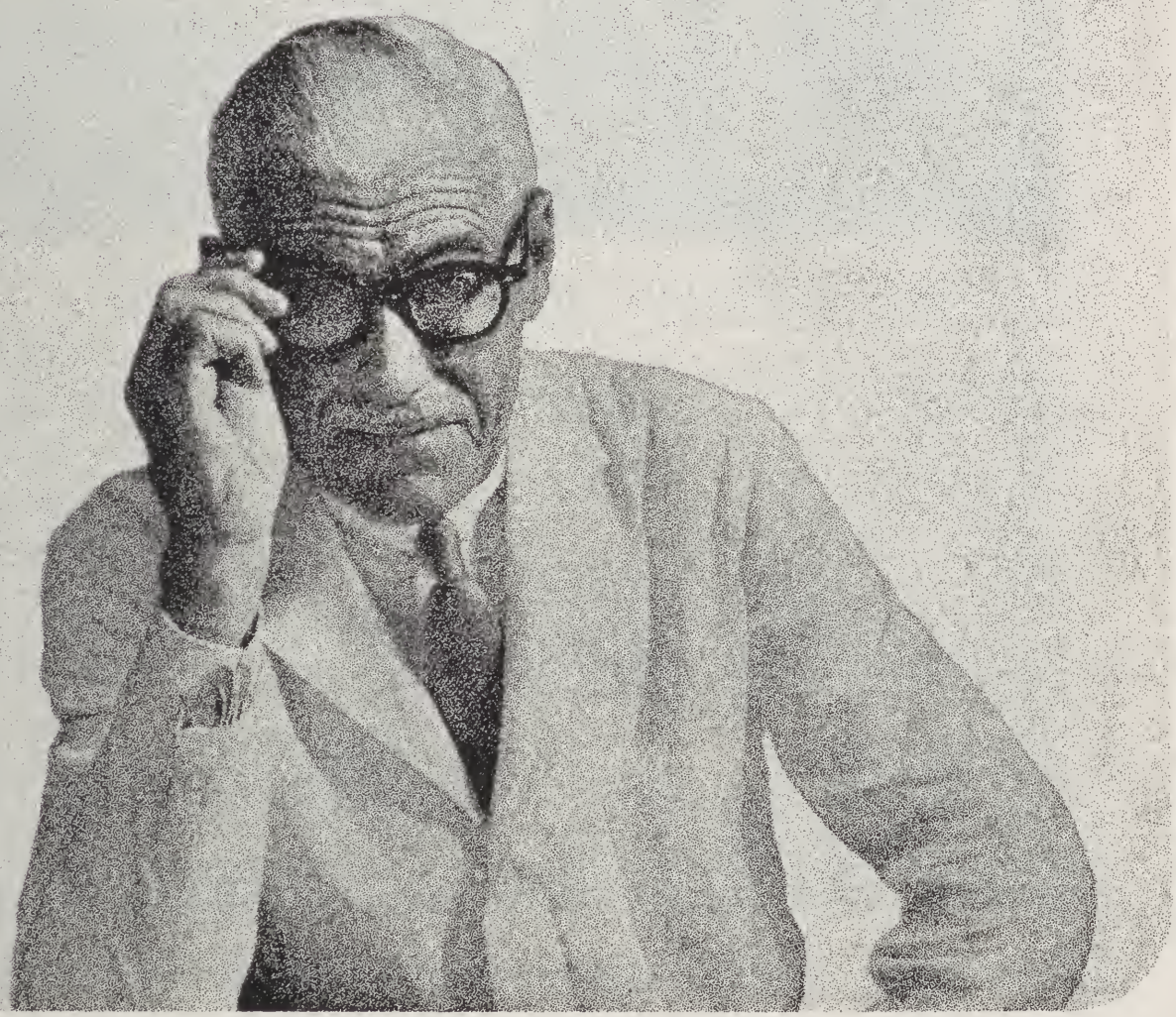
High incidence:	Annual new cases number about 73,000. Deaths now total 46,000 a year.
High curability potential:	Early diagnosis and prompt treatment could save almost 75%. Survival rate is now only 44%.

How to close the critical gap between possible and actual survivals?

The "procto" can today help save more lives from cancer than any other step in the checkup. Which is why, in our constant emphasis on the importance of annual checkups, we urge the inclusion of a "procto" ...and make available films and other pertinent materials for the layman and the physician. We *are* closing the "communications" gap.

Joint action by people and their doctors can help close the "action" gap to reach a cure rate of almost 75% for colon and rectal cancer.

American Cancer Society®



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V-Cillin K®, Pediatric dependable oral penicillin therapy

Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K® (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567A] 800198

Additional information available to physicians upon request.

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The Month in Washington

The American Medical Association protested strongly against proposed new medicaid regulations affecting payments to physicians and utilization review.

The proposed regulation on physicians' reasonable charges was described as an anomaly in a protest to the Department of Health, Education and Welfare.

In the protest, filed with the Department of Health, Education and Welfare, the AMA termed the proposed regulation on physicians' "reasonable" charges as an anomaly because it is based on payments received, with no consideration given to the usual and customary fee.

Since medicare payments made by the government are 80% of the reasonable charge, this amount could become the maximum of every charge under medicare, the AMA said. Or, were physicians to receive less than full payment, and write off losses, the reduced payments could become the basis for the reasonable charge under medicaid.

The new regulation on utilization review would require a state medicaid plan to provide for utilization review of each item of service, including services performed in a physician's office or the patient's home. The AMA said it could lead to a set of national standards with authorized treatment for each medical condition limited in a manner set by regulation.

The AMA said it is not opposed to a "claims review" process to that now in operation in many areas or as conducted under medicare. Nor, the AMA added, did it find fault with inquiring into a physician's conduct where fraud is alleged, or where it appears on the basis of medicare claims submitted, that there is reasonable ground for further investigation of a possible fraud.

In another development, the Advisory Commission on Intergovernmental Relations supported a medicaid goal of comprehensive health care for the needy and medically needy by 1975, but proposed changes in financing and operation of the federal-state program.

The report was directed particularly to "the virtually unmanageable fiscal burden imposed on state and local governments by the program." It urged that consideration be given to "broadening medicaid's financial base through increased involvement of the private sector through an employer-employee contributory health insurance system." If congress approved this proposal, it would be a giant step toward national compulsory government health insurance.

The commission rejected proposals to limit federal sharing in medicare and to establish national eligibility standards for beneficiaries.

The report was made public soon after the Senate voted a $500 million cutback in medicaid funds and when some states already were trimming their medicaid programs because of a financial pinch.

The commission recommended that the states "move vigorously to experiment with methods of increasing the efficiency and economy of health services under the medicaid program," including: ● Reimbursing hospitals contingent on their operating under an acceptable standard of management efficiency; ● expanding prior authorization for elective surgical procedures; ● payment for physicians' services on a basis other than "usual and customary" charges; ● use of co-payments for the purchase of specified health care services; and ● improved techniques of utilization review.

The 26-member commission is a bipartisan body established by federal law in 1959 to main-

tain continuing review of the relations among federal, state and local governments. Its membership consists of governors, mayors, county officials, state legislators, and representatives of both houses of Congress, the federal executive branch, and the general public. The chairman is Farris Bryant, former governor of Florida.

*** *** ***

Congress approved a two-year extension of the regional medical programs and a one-year extension of the Hill-Burton program of federal aid for construction of hospitals and other health care facilities.

The legislation authorizes appropriation of $65 million in this fiscal year, ending next June 30, and $120 million for the next year for the regional medical programs. The Senate had voted a three-year extension but it was dropped in a House-Senate conference which worked out the compromise.

House conferees, however, emphasized that "this program, although a newly established one, has already proved its value and should be considered as a permanent program." They said they accepted the two-year extension to give the next Congress an opportunity to review the program.

The Hill-Burton program authorized $195 million for hospitals and $100 million for other health care facilities. The conferees abandoned Senate provisions for a new three-year program of federal loans of $200 million a year for hospital modernization and a guaranteed loan program of the same amount with a federal subsidy of interest. These provisions also were left for further consideration by the next Congress.

A total of $40 million was authorized for two years for construction and staffing of rehabilitation facilities for narcotics addicts and alcoholics. As a declaration of Congress, the measure states:

"Alcoholism is a major health and social problem afflicting a significant proportion of the public and much more needs to be done by public and private agencies to develop effective prevention and control."

The program of grants for family health service clinics for migratory agricultural workers was extended for two years with $9 million authorized for the current fiscal year and $15 million for the next year.

*** *** ***

Congress approved legislation designating November 17-23, 1968 as "National Family Health Week." The legislation termed the week "as a means of focusing national attention, during the year, upon the accomplishments of the American health care system and the central role played by the family physician in the maintenance of superior medical care for Americans of all ages and from all walks of life."

*** *** ***

The Committee on Emergency Medical Services of the National Research Council has recommended establishment of a nationwide program for the training of ambulance personnel.

The committee proposed guidelines for such training, stating that there is at present "no uniformity in the course of instruction and . . . no generally accepted standards of proficiency to be used by those empowered to certify ambulance personnel."

The committee's recommendations cover: either the standard or advanced First Aid courses of the American National Red Cross as a prerequisite, the operation of emergency vehicles, safety precautions at the accident scene, priorities of care, records, the use of communication systems, the use of equipment and supplies, medicolegal problems, and rescue procedures.

The levels of proficiency, designed to result from the course proposed in the report, are attainable in most areas of the country within a reasonable time, the committee said. However, to realize the greatest life-saving potential, the ambulance attendant of the future should be trained to the same level as lay assistants in emergency departments or medical corpsmen in combat areas; and, ideally he should be qualified to carry out, either independently or through voice communication with a physician, such procedures as tracheostomy, defibrillation, and mechanical external cardiac compression, the committee said.

To attain these goals, the committee stated that accredited hospital training programs must be established that will produce professional ambulance attendants and emergency department assistants of the caliber of certified X-ray, laboratory, physical therapy, and other accredited medical technicians.

The ambulance attendant must be fully engaged in emergency care in an established

career pattern that provides attractive compensation, prestige, and recognition deserving of his services as a member of the emergency care team. Where the needs for ambulance services are low, so that he is not fully occupied, such as in small communities, he should be an employee of a hospital, where he can maintain his interest and proficiency as an assistant in the emergency department, intensive-care unit, or operating room, the committee said.

*** *** ***

The President's Committee on Mental Retardation reported that three fourths of the nation's six million mentally retarded live in urban ghettos and rural slums and were unwanted, unplanned children.

The committee's second annual report, entitled "The Edge of Change," dealt with the high incidence of retarded development among the poor, the shortage of manpower to serve the retarded, and the low quality of residential care available to most of them.

The committee's recommendations called for:

- Education and health services for every child from birth.
- An insurance system to give parents a free choice in selecting needed services.
- Development of national accreditation standards for residential facilities for the retarded.
- Voluntary family planning services for all Americans.

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INFECTION CONTROL IN THE HOSPITAL, American Hospital Association, Chicago, Ill. 1968.

This paper back publication fills the need for an up-to-date handbook that provides in one place all the things hospital workers must know in order to be maximally effective in the control of nosocomial infection.

It is intended to be handy desk reference, from which the hospital worker on the job can readily obtain the information he needs.

This publication does this job well.

DEAR DOCTOR by Juliet Lowell, published by Funk and Wagnalls, New York City, 1968.

This collection of "zany" letters, reported to be, "all genuine, all incredible" make laughable reading. While it cannot be recommended for addition to a medical library, it certainly can be recommended for use in the doctor's waiting room, for gifts to friends or other such useful purposes.

MEDICAL PHARMACOLOGY, PRINCIPLES AND CONCEPTS, by Andres Goth, MD; The C. V. Mosby Company, St. Louis, Mo. 1968.

This fourth edition is similar in its basic objective to the previous editions. It attempts to present in a concise manner those principles and concepts of pharmacology that are necessary for the proper utilization of the therapeutic agents available to the physician.

This edition, however, places increased emphasis on the basic aspect of the mode of action of drugs. Also, it includes a new chapter on contemporary drug abuse.

This book is a must for every medical library in existence.

Walter Reed's First Nursing Graduates

The Walter Reed Army Institute of Nursing, better known as WRAIN has graduated its first class of nurses from the University of Maryland School of Nursing's Center in Washington, D. C.

The 60 graduates were awarded bachelor of science degrees in nursing at the university's commencement exercises in College Park. They were commissioned as second lieutenants in the U.S. Army at ceremonies held at the Walter Reed Army Medical Center. They will be assigned to Army hospitals scattered throughout the U.S.

WRAIN came into being in 1964 through a unique contract between the University of Maryland and the Department of the Army, designed to help relieve the critical shortage of nurses that exists not only within the Army but throughout the nation.

Under this program, qualified students are awarded scholarships that meet nearly all educational expenses for study toward a baccalaureate degree in nursing, provided they agree to enlist in the Army at pay grade E-3 (private first class). They may enroll for all four years at the University of Maryland or transfer there after two years at another accredited college.

Competition is keen for the 135 scholarships awarded each year—last year there were more than 600 applications from all over the nation. The ultimate goal is 100 graduates a year.

By making the Army's vast clinical resources available to the University of Maryland for the preparation of nurses, and by making financial assistance available to qualified candidates, WRAIN is making an important contribution to the nursing needs of the nation.



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MEDICAL NEWS



At a recent testimonial dinner John A. Askin, MD, was honored for his many years of dedicated service to the Baltimore community. The Dr. John A. Askin Pediatric Research and Post Graduate Institute being established in Israel is an affiliation between the pediatric facilities in that country and the Department of Pediatrics at The Johns Hopkins Hospital. Pictured at the dinner are: (left to right) Louis V. Blum, MD, dinner chairman; Herman Seidel, MD, honorary chairman, Israel Histadrut Council; Harry Gordon, MD, Dean, Albert Einstein College of Medicine; Mrs. Askin and Dr. Askin; and Robert E. Cooke, MD, professor of pediatrics, The Johns Hopkins Medical School and Hospital.

Richard B. Norment, MD, and Frederick J. Hatem, MD, of 600 South Union Ave., Havre de Grace, have announced that **Khosro Namvary, MD,** is now associated with them in the practice of Obstetrics and Gynecology.

Associated with Harford Memorial Hospital's resident staff since November 1967, Dr. Namvary served as a house physician in his specialty, and will become a member of the hospital's associate staff.

* * *

Emmanuel Schimunek, MD, has been named to represent the Medical and Chirurgical Faculty on the Committee on Local Arrangements of the American Association for the History of Medicine. The Association is holding its forty-second annual meeting in Baltimore, May 8, 9, and 10, 1969. It will be the guest of The Johns Hopkins University, which is celebrating the 75th anniversary of the opening of The Johns Hopkins Medical School.

* * *

The following members of The Medical and Chirurgical Faculty have been appointed Health Representatives on the State Health Planning Council of the State's Comprehensive Health Planning Agency: **Irving I. Abramson, MD, Raymond T. Benack, MD, John T. Chissell, MD, Daniel L. Finucane, MD,** deputy State health officer, Prince George's County Health Department; **Russell S. Fisher, MD,** chief medical examiner, Department of Post Mortem Examiners; **Robert W. Gibson, MD,** medical director, The Sheppard and Enoch Pratt Hospital; **John Collins Harvey, MD,** medical director, The Good Samaritan Hospital; **B. Martin Middleton, MD, Russell A. Nelson,** president, The Johns Hopkins Hospital; **Ross Z. Pierpont, MD, J. Emmett Queen, MD,** director of medical education, Bon Secours Hospital; **Harry M. Robinson, Jr., MD,** Professor

of Dermatology, University of Maryland School of Medicine; **Alexander J. Schaffer, MD, William S. Spicer, Jr., MD,** coordinator, regional medical program for Maryland; **Ernest L. Stebbins, MD,** director, Program in Comprehensive Health Planning; **George H. Yeager, MD,** director of professional and supporting services.

Aris T. Allen, MD, has been appointed Consumer Representative.

Governor Spiro T. Agnew is chairman of the Agency, and **William J. Peeples, MD, MPH,** is vice-chairman.

* * *

John W. Williamson, MD, associate professor in The Johns Hopkins University School of Hygiene and Public Health Department of Medical Care and Hospitals, received a five-year Milbank Faculty Fellowship to continue his work in measuring the end results of medical care and in developing methods for quantitatively estimating potential benefits to populations provided optimum care. He is especially interested in relating the results of these investigations to the problems of postgraduate education. Dr. Williamson's Milbank Faculty Fellowship will permit further development of instruments he has designed to enable practicing physicians to assess the care they provide their own patients. He is presently conducting studies at The Johns Hopkins Hospital, the Baltimore City Hospitals, and with the Regional Medical Programs.

David L. Rabin, MD, MPH, an associate professor in the Department, was granted increased funding for his Fellowship, which began its five-year term in 1967. Dr. Rabin is project director of the Baltimore phase and co-ordinator of an international survey on the use and availability of medical facilities.

One purpose of the Milbank Faculty Fellowships is to allow promising medical investigators in medical care and community medicine exceptional freedom to study problems of potential importance to society on a long-range basis.

* * *

A. C. Nolan, MD, who has been a resident in Physiology in the Mayo Graduate School of Medicine, University of Minnesota at Rochester, will be located in Bethesda.

* * *

Two Baltimore surgeons have joined The Professional Forum and have accepted appointments to this group's Committee on Medicine.

John M. Rehberger, MD, FACS, will serve as a vice chairman of the Section on Otolaryngology from 1968 to 1970.

Fred N. Cole, Jr., MD, will serve as vice chairman of the Section on Thoracic and Cardiovascular Surgery from 1968 to 1970.

Also serving on this committee are **Ray J. Beasley, MD, Newland E. Day, MD, Joseph H. Hooper, Jr., MD, Raymond L. Markley, Jr., MD, Robert McFadden, MD, Douglas H. Stone, MD, and Henry L. Wollenweber, MD.**

William E. Gilmore, MD, is chairman of the Forum's Committee on Medicine and a co-founder of the interdisciplinary association, which provides guest speakers from the disciplines of law, medicine, dentistry, professional accountancy, political science, psychology and criminology to lay audiences of every composition.

Mr. John Sargeant is the liaison advisor between the Professional Forum and county, State and national medical associations.

* * *

Hans R. Wilhelmson, MD, and **Jerome S. Plasse, MD,** have announced their association in the practice of plastic reconstructive and hand surgery. Their office is located at 301 Medical Arts Building in Baltimore. The office hours are by appointment.

* * *

Giovanni Di Chiro, MD, of Bethesda, addressed the members of the American Roentgen Ray Society during its annual meeting, October 1-4, in New Orleans. His topic was "Isotope Cisterno and Ventriculography."

The oldest U.S. medical specialty society in radiology, the ARRS celebrated its 69th year during the convention. More than 2500 people attended the four-day meeting.

* * *

Leeds Katzen, MD, has been named assistant medical director of the Medical Eye Bank of Maryland.

Dr. Katzen, who received his MD from the University of Maryland Medical School

and interned at Mercy Hospital, is chief of the Mercy Hospital Eye Service.

The Medical Eye Bank of Maryland is recognized as the largest of the 86 banks in the country which collect eye tissue from deceased persons for use by ophthalmologists in restoring the sight of people injured in accidents or afflicted with certain kinds of blindness.

* * *

Charles E. Wright, MD, was guest speaker at the September meeting of the Frederick County Association for Retarded Children.

Dr. Wright received a Bachelor of Arts Degree from Centre College of Kentucky in 1951 and a Medical Degree from The Johns Hopkins Medical School in 1955. He served a rotating internship at the University of Maryland Hospital in Baltimore.

After two years of active duty as a medical officer in the army, Dr. Wright continued with a two-year pediatric residency at the University Hospital. In the year 1960-61 he worked at The Johns Hopkins Hospital with Harriet Guild, MD.

Dr. Wright has been practicing pediatrics in Frederick since 1961.

* * *

Edward Ford MacNichol, Jr., PhD, professor of biophysics at The Johns Hopkins University, has been appointed director of the national Institute of Neurological Diseases and acting director of the newly established National Eye Institute.

Dr. MacNichol will have overall responsibility for the programs of both institutes—including research programs on the National Institute of Health campus in Bethesda, Md., and in Puerto Rico, research and training grants programs and collaborative and field-research studies.

* * *

More than $1.2 million in scientific grants and fellowships have been awarded during 1968 by the **Life Insurance Medical Research Fund.**

The Fund, supported by more than 130 insurance companies in the United States and Canada, presents the awards annually to aid basic medical research. Since 1945, more than $23 million in grants and fellowships have aided 498 institutional projects and 387 individuals.

The Johns Hopkins University has received $33,000 for research by **Mackenzie Walser, MD,** on the role of membrane-bound cations in the mechanism of ouabain action.

* * *

J. M. Bilstad, MD, who has been a resident in Internal Medicine in the Mayo Graduate School of Medicine, University of Minnesota at Rochester, will be located in Bethesda.

* * *

Robert J. Wilder, MD, has been named president of the newly formed Baltimore Metropolitan Division of the Heart Association of Maryland.

Dr. Wilder earned his BA degree at Columbia University and then was graduated from the Columbia College of Physicians and Surgeons with his medical degree.

After internship at Presbyterian Hospital at Columbia Medical Center, Dr. Wilder served three years as Assistant Resident in Surgery at New York's Mount Sinai Hospital.

Moving to Baltimore in 1956, he became resident in surgery at Baltimore City Hospitals, and then assistant chief of surgery. He also began to parallel his medical career with that of an educator. He started as an instructor in surgery and became assistant professor of surgery at The Johns Hopkins University.

Dr. Wilder is a prolific medical writer who is the author of a book and over 47 papers and publications. These range from highly technical items of a surgical nature to a new plan for civilian emergencies titled "Emergency Squad Doctor."

In addition to his academic position with The Hopkins, Dr. Wilder is presently the attending cardiovascular surgeon at Sinai Hospital, chest consultant to Loch Raven Veterans Administration Hospital, and staff member of other hospitals in Baltimore.

* * *

On August 19, 1968, **Allen V. Astin, PhD,** Director of the National Bureau of Standards, and **Wilson H. Elkins, PhD,** President of the University of Maryland signed a memorandum of understanding providing for cooperation between the two organizations to enlarge the scientific competence and breadth of both institutions.

This is to be accomplished by: making greater use of the national investment in scientific personnel and facilities at NBS for graduate educational and research purposes; bringing university competence

more strongly to bear on appropriate problems relevant to national goals; providing increased opportunity for quality graduate study and advanced education at both institutions; encouraging and facilitating mechanisms for effective collaboration between the University of Maryland and the National Bureau of Standards in joint programs.

NBS employees will participate in University research and training programs, and University faculty and students will be encouraged to use NBS facilities and to interact with NBS staff.

The two institutions will also seek to attract distinguished scientists to positions at either institution.

* * *

"The Nose and Man's Atmospheric Environment" is the topic of a paper presented by **Donald F. Proctor, MD,** at the American Medical Association's ninth annual Air Pollution Research Conference in Denver, Colorado.

Dr. Proctor, professor in the department of environmental medicine at The Johns Hopkins School of Hygiene and Public Health, heads a study on air hygiene established through grants from the National Heart Institute and the National Center for Air Pollution Control.

"Our project is something of a pace-setter," says Dr. Proctor, "in that—despite all the hue and cry about air pollution today—there has not been much biologically-oriented research on the problem. Most of the studies have been in the areas of engineering; ie how to rid the air of industrial, automobile, and other wastes, how to build factories and heating systems which release less pollution into the atmosphere, etc."

Dr. Proctor noted that, during more than 30 years of medical practice, he has seen countless patients with nasal and upper respiratory problems which, as he puts it, "we simply lack the necessary knowledge to relieve." It is in the hope of linking air pollution research more closely to actual clinical problems that he and his team at the School of Hygiene and Public Health have established their study.

By focusing on the role of particles such as industrial waste and other inert matter, air pollution research has tended to ignore a number of crucial "atmospheric effects." "It makes good sense to include viruses, bacteria, humidity, heat, and other environmental entities in the same category," he said.

The study has been in operation for three years, and Dr. Proctor feels its usefulness is just beginning.

* * *

A Respiratory Care Center has been opened at 6301 N. Charles St., Baltimore, Maryland for the treatment of outpatients with chronic pulmonary disorders. The services of the clinic include: intermittent positive pressure therapy, humidity treatments, diagnostic spirometry, and chest physiotherapy.

The staff consists of: **Charles F. Hobelmann, MD,** Medical Director; **Richard L. Trader, ARIT,** Chief Inhalation Therapist; **Ernest A. Burch, RPR,** and **William E. Rhoads, RPT,** Physical Therapists. The inhalation therapists are: **Tim A. McFarland, Louis H. Brecht, Joseph Carl Friia,** and **David Gade.**

The clinic will be open Monday through Friday, 9 AM to 5 PM and Saturday and Sunday, 9 AM to 1 PM.

* * *

A unique new cancer clinic which consolidates the interests of several disciplines in the area of cancer has been opened at The Johns Hopkins Hospital.

Albert H. Owens, Jr., MD, director of the project, said the development of the clinic is the first step in a much larger project to mount and maintain a coordinated, multidisciplinary program concerned with the problems of cancerous diseases, and the diagnosis and treatment of cancer patients.

In addition, he said, the program will add breadth and depth to the training opportunities now available to medical students and physicians.

Five clinics that have met separately will come together as the **Grant E. Ward Conjoint Oncology Clinic.** The five clinics are radiotherapy, oncology, hematology, surgical tumor and breast.

The clinic will enable cancer patients to be identified early in their illness. It also will enable them to receive comprehensive medical care throughout the entire course of their illness.

In addition the clinic will provide a focal point where physicians in the community and affiliated hospitals can obtain consultation services and specialized treatment for their patients.

* * *

your medical faculty at work

by John Sargeant
Executive Secretary

The House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland met on Thursday, September 5, 1968 and Friday; September 6, 1968, in Ocean City, Md., and took the following actions:

1. Elected various members to Emeritus status.
2. Adopted a bylaw change that would enable Doctors of Osteopathy who hold licenses to practice medicine and surgery in Maryland to become active members of the Faculty, if they qualify. It also authorized the Faculty's delegates to the AMA House of Delegates to introduce a resolution dealing with an appropriate and similar change in the AMA By-laws.
3. Accepted a report from the Bylaws Committee that recommended no bylaw changes to:
   (a) allow the Council to provide legal defense even though a physician had not paid his dues by January 31 of the year in which the alleged offense occurred; and
   (b) deferred action, at this time, in establishing Council representation by district, based upon numerical membership in each district.
4. Received the report of the Faculty's delegates to the AMA.
5. Adopted a proposed revised Medical Practice Act for submission to the Legislative Council and, hopefully, adoption by the General Assembly.

Friday, September 6:

6. Adopted the following substitute motion, as offered by the Policy and Planning Committee: *Resolved,* That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland favors 100% membership in the Woman's Auxiliary on a voluntary basis, but is of the opinion that a statewide assessment or dues increase creating involuntary membership would be unwise. Component Societies are encouraged to consider this matter individually, in order to arrive at the most equitable arrangement for each group.
7. Adopted a resolution endorsing the incorporation of self-employed persons.
8. Postponed action on a resolution dealing with payment of Usual, Customary and Reasonable fees for Workmen's Compensation Cases until the Annual Meeting, 1969.
9. Adoption resolutions honoring the late Mr. Walter N. Kirkman, and the late Walter D. Wise, MD, Faculty past-president.
10. After a roll-call vote, defeated (49-47) a motion to ask the U. S. Department of Health, Education and Welfare to investigate the legality of Maryland's current Medicaid program.
11. Adopted a resolution calling for continued discussions along with other providers of health care services with appropriate state government officials for the purpose of presenting a unified approach to an effective and satisfactory solution to the Medicaid program in Maryland.
12. Presented a Viet Nam plaque to Frederick M. Zerzavy, MD, for his volunteer service in Viet Nam under the AMA Volunteer Physicians for Viet Nam program.



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In childhood



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Senra del Valle and his associates[1] conducted a study of 477 children with diarrhea, most of whom were hospitalized with the disorder. Lomotil, used in 407 of the children, shortened the duration of the diarrhea.

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Michener, Brown and Turnbull[4] added evidence supporting the beneficial effects of Lomotil in 80 children, concluding that Lomotil was highly useful in controlling abdominal cramping, diarrhea and hypermotility.

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dults: . . . . 2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

ased on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

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EDITORIALS

Maryland State Medical Journal
Volume 17, Number 11
November, 1968

JOURNAL ADVERTISING—

Every month, as one of my editorial emoluments, a medical journal appears on my desk which is unique among its fellows. It is unique on two counts: It travels much farther than the others and it does me less good. Its failure to be of service lies in no defect of its own but in me . . . I cannot read Russian. Still, I am fascinated by its novelty and usually manage to learn the tenor of its articles by figuring out a word here and there, by studying the charts and illustrations . . . and by reading the summaries in English.

I strongly suspect that it is a highly scientific and valuable publication. But it has another feature which is even more distressing to me than my inability to read it. There are no ads! At first blush this might seem appealing, especially to those physicians who believe that they acquire all of their knowledge by perusing words and tables and illustrations and by immediately and methodically stacking the information in their memory banks.

As for me, the absence of advertising in my Russian journal has caused me to reconsider the place of advertising in continuing medical education and I think that it holds an important place. I think that the knowledge of the practitioner comes from a combination of hard study, experience, cursory study, casual exposure to information and ideas in the course of talking to doctors, nurses, detail men, pharmacists and many others. The intake from these sources is not neatly structured, at first, but has a changing and nebulous form as it grows and shifts. I suspect that a number of fixed points in this body of knowledge come from the repeated exposure to the kinds of information which come to the eye of the doctor as he scans the advertising in his medical journals. The beginning of therapeutic wisdom may lie in this brief but vivid exposure. Depths of wisdom, of course, demand deep study and reflection and experience as a sequel to this initial awareness. Only after such study is the arrangement orderly and fixed.

We practitioners are all indebted for this first increment of wisdom in treatment to those important members of our competitive free enterprise system, the pharmaceutical manufacturers. I am convinced that their contribution, their advertisements, their promotions, form an important, an integral part of our journals. I hope that we do not limit its freedom in the pursuit of truth in advertising to the extent that it is no longer the vivid first insight of knowledge. I hope that we do not see it regulated out of existence.

I am willing to take more of a chance with our country's physicians in this matter of acquiring therapeutic knowledge than is our Food and Drug Administration. This agency worries lest an overstatement or a misstatement creeps into the advertising. They fear that an improper emphasis may be given to one feature or another in the story of a medicament. I think that they undervalue my profession. A grain of salt is always in the doctor's eye as he scans the advertisements. He can be counted on to use these presentations for what they are—promotions of armaments from which he can select his weapons against his patient's ills.

CARL B. LECHNER, MD

Reprinted from Pennsylvania Medicine, *August, 1968, with permission.*



YES OR NO?

THE NOTION that advertising does not have a legitimate place in the dignified scientific journal has been generally dispelled. Editors and readers alike agree that advertising is informative and useful. At the same time, of course, the income from advertising sales allows a quality journal to be published while keeping society membership dues and subscription prices to a minimum.

There are several important considerations in determining whether an advertising sales program is advisable:

The fundamental step to be taken in deciding to sell advertising space, as well as in evaluating the success of the current sales program, is to define the actual sales market. Only those manufacturers whose products are purchased by or through the readers of the journal can be considered as potential purchasers of advertising space. A check of the advertisers in competitive journals will reveal the probable size of the sales market. For one-of-a-kind journals, this must be determined by direct contact with the manufacturers.

In general, if a journal does not have the potential to sell 10 pages or more of advertising space per issue, it is probably not worthwhile to be in the business of selling it. The small circulation of the ordinary scientific journal keeps the advertising page rate low, but the costs of selling the ad, processing it, billing the advertiser, and collecting the money can be considerable. The average scientific journal, operating an advertising sales program independently, would spend more money than it could possibly make . . . only a few are able to operate independently, and, at that, the margin of profit is necessarily reduced.

For example, 30 pages of advertising per issue at about $200 per page will gross a monthly journal $72,000 annually. After the printing cost (about 50% of the gross) is deducted, most of the remaining $36,000 will be spent on a salesman's salary and travel expense. If there were no salesman, it's not likely the journal would gross anything like $72,000 in the first place.

If a journal has advertising sales potential, the obstacle presented by the costs of selling and administration can be overcome by purchasing these services. There are many national advertising sales organizations that will supply sales representation for a reasonable fee; they can do this because they sell space in many journals at once. A journal that is going to buy advertising sales services must make sure the concern is reliable. Certainly, no journal wants its reputation impaired by inappropriate sales representation. At the same time, the journal should seek a sales organization that is already successfully selling to a market similar to its own market.

Another consideration is the danger of overreliance on advertising income. We must constantly remind ourselves that advertising income, by its very nature, is the least stable revenue source for the journal. Before publishing decisions are made on the basis of this anticipated income, a careful appraisal of the sales situation should be made.

DANIEL H. COYNE

Excerpted from The Kalends *of the Waverly Press, July-August, 1968.*

Straight Pin Ingestion in an American Indian Boarding School

The ingestion of foreign bodies is not too unusual. However, the allegedly accidental ingestion of straight pins by two young American Indian school boys is somewhat unusual. The different treatment employed in the two cases and the discussion of sharp objects in the gastrointestinal tract warrant these case presentations.

Exactly what treatment is recommended when sharp pointed objects or foreign bodies with sharp edges enter the stomach?

CHARLES FORREST SPARGER, MD
Silver Spring, Maryland

It has long been recognized that when a foreign body becomes lodged in the esophagus peroral removal by magnets [1,2] and/or endoscopic means [3-14] (including use of flexible forceps) is indicated; failure to do so may result in perforation of the esophagus and/or other complications.[14-20] However, once the foreign body enters the stomach and/or the intestinal tract the solution is not so simple, and *the solution depends upon the circumstances in each case.*[8]

In the past, in the case of patients who were observed for long periods, it was simply hoped that the foreign body would not perforate despite apparent partial obstruction. It seems that in many instances the patients were simply observed for long periods until the object passed per rectum or until signs of perforation had occurred.

The urgency of removal by suction and/or special magnets, and/or gastroscopy, of any object that presents potential danger of perforation before it leaves the stomach has been stressed.[4] Based on the reports of various authors, theoretically, any object found in the stomach with a point or sharp edge should be removed while it is still in the stomach to avoid potential perforation of the gastrointestinal tract.[21,22] Certainly when the literature concerning perforation of the gastrointestinal tract by sharp objects is reviewed, one is somewhat less eager to assume a watch-and-wait policy. One must remove each object in the stomach, depending on the circumstances, the safest way possible for a particular patient.

Chevalier Jackson noted that, "In cases of pins, needles, safety pins, and similar objects the chance for safe passage through the intestine is fairly good; but the occasional course of ulcerative perforation renders gastroscopic removal advisable, if this can be done before the foreign body has left the stomach." [21,22] It has been claimed that by utilizing the biplane operative fluoroscope, any foreign body in the stomach can be removed from the stomach.[22] However, Drs. Van Loon and Diamond noted that: "In certain cases peroral endoscopy is the method of choice. In others the object may be removed by laparotomy. In a large number, conservative watchful waiting in

anticipation of spontaneous passage from the bowel is the wisest policy."[8] It is recognized that too early a laparotomy is less than ideal,[23] but also that prolonged multiple efforts at endoscopic removal can be dangerous.[1,19,21,24]

Based on the above backgrounds, and because of the different hospital courses in these two Indian patients, different treatment was given. The presentations follow:

Case One: While attending an American Indian Boarding School this ten-year-old Navajo male student accidentally swallowed a straight pin on the day of admission to the U.S.P.H.S. Hospital, Gallup, New Mexico, on November 24, 1965. Both the initial and subsequent X-ray revealed the straight pin to be in the stomach. (Fig. 1) Therefore, because of the possibility that the pin was stuck, and recognizing that perforation by sharp objects can occur without early (or very mild) symptoms,[25] and because of the tendency of some straight, pointed foreign bodies not to pass through the duodenum and/or to perforate the alimentary tract, it was decided to make a small abdominal incision and to manipulate the pin through the wall of the stomach or to remove the pin by gastrostomy.



Fig. 1—Reveals pin in stomach. Both initial and follow-up films revealed pin in stomach.

Apparently the initial manipulation of the stomach forced the straight pin into the esophagus as confirmed by an operative X-ray. (Fig. 2) It is possible that moving the patient had displaced the pin so that esophagogastric suction during the procedure had been an effective force in causing the pin to move retrograde into the esophagus. Consequently, without having incised the stomach, one of the surgeons dropped out of the operating field and removed the pin by esophogoscopy. Since there had been no contamination of the field (as the stomach had not been entered) the patient had a prompt and uneventful course. It was learned retrospectively that a variation of this technique had already been described.[4]



Fig. 2—Arrow points to tip of pin which apparently after being freed was manipulated back, at least partially, into esophagus.

Case Two: While attending an American Indian Boarding School this twelve-year-old Navajo male student, friend of "Case One," allegedly accidentally swallowed two straight pins that he had in his mouth on the morning of November 26, 1965, the day he was admitted to the U.S.P.H.S. Hospital, Gallup, New Mexico. He denied any attempt to achieve "status" by swallowing a straight pin, and denied any attempt to mimic his friend. A nasogastric tube was passed and an attempt was made to remove the pins with suction but without success. Since, unlike "Case One," on X-ray examination there appeared to be rapid progress of the pins, it was decided therefore to use the high residue diet routine in this case. This routine (as is true in the majority of cases) was a prompt success, as the two pins were found in his stools the next day. Routine radiological films were made, and no foreign bodies were seen.

Discussion

These two cases tend to support the theory that children have a universal habit of putting everything that they handle into their mouths. Regardless of the exact cause of ingestion in these two cases, it was allegedly due to carelessness in each case and according to Jackson 80% to 90% of the foreign bodies lodged in the food passage are the result of carelessness.[13,25,26] These two cases fall in the most common age group, specifically under 15 years of age.[26]

In "Case One," since no gastric foreign body magnet, direct (open) gastroscope, nor flexible gastric foreign body forceps, nor operating biplane fluoroscope were available, and since the pin did not seem to be making progress, and since, with Navajo patients, there may always be a problem of getting consent, especially if no operative action of any type is taken immediately; it was decided to proceed with a small incision and to attempt to manipulate the straight pin through the stomach wall[12] (somewhat similar to the procedure used by MacQuigg and Lee on the lung) or else to remove the pin by gastrostomy.[12,24] It has been recognized that symptoms, when a sharp, pointed, foreign body is perforating, may occur late.

On palpating the stomach wall the pin was not palpable and a portable X-ray revealed the tip of the pin just beyond the cardiac orifice so that it was readily removed by esophagoscopy. As noted previously, it is probable that the initial manipulation had possibly freed the pin and had caused it to pass antegrade; although it is possible that the gastric suction had been a factor also.

Consents may be difficult to obtain from various patients[8,18] or relatives, but when Indian parents do not comprehend the problem it may be especially difficult to obtain their consent. In addition, if "definitive therapy" is delayed, then, when one attempts later to obtain a consent, the parent may not only fail to consent, but may remove the patient from the hospital, not to return until complications occur.

Although it has been estimated that of those foreign bodies entering the stomach, by way of the esophagus, the vast majority will pass through the remainder of the normal intestinal tract,[4,8] it is obvious that the round- or smooth-edged foreign body is not as likely to perforate as the pointed or sharp-edged object and can be watched over a longer period of time.[8,24,27] In supporting the gastroscopic removal of foreign objects Jackson and Jackson noted that ferrous bodies that were lodged in the stomach or proximal one-third of the duodenum could be removed by a magnet; however, they noted that it would not be possible to remove the nonferrous object from the duodenum with a magnet and hence any such object that lodged in the duodenum would require surgery and that this was an unfavorable location to operate.[1]

Various authors have recognized the tendency of sharp objects to ulcerate and/or perforate. Types of foreign bodies that have been caught and/or have perforated the gastrointestinal tract have included the following: A case of fatal hemorrhage due to the perforation of a renal artery by a fish bone as described by Kearney[11]; Lell reviewed a personal communication, relative to a needle penetrating the abdominal aorta and entering the systemic circulation; he also mentioned a nail lodged in the duodenum; a bobby pin lodged in the duodenum that required a laparotomy[4]; intestinal perforation (due to swallowing fish or meat bone—four cases in which fish or meat bone were discovered at laparotomy) of the caecum, transverse colon, ileum and hepatic flexure.[3] Snodgrass reported a case of his own and noted 20 other cases of either toothpicks or slivers of wood that had perforated the intestine.[7] Rejtvar reported fishbone perforation.[34]

Ward-McQuaid reviewed six cases of perforation of the intestine. Five of his six were due to sharp objects and included rabbit rib, rabbit scapula, safety pin, a piece of wire, and a sewing needle.[6] Additional foreign bodies that have gotten caught and/or perforated the gastrointestinal tract have included: perforation of a Meckel's diverticulum by a gramophone needle[28]; perforation of a Meckel's diverticulum by a cabbage stalk.[10] McManus, in 1941, reviewed 93 published cases of perforation of the gastrointestinal tract by sharp, foreign bodies and added two of his own including the case of a piece of wire perforating the small intestine.[5] In addition there was a case of two needles that penetrated the wall of the stomach *eight hours* after ingestion[8]; a needle surrounded by a thrombus in the inferior vena cava [29]; a hair pin arrested in the second part of the duodenum requiring laparotomy[8]; an arrest of a piece of wire in the duodenum requiring laparotomy.[8] It has been noted that of 63 cases of foreign body appendicitis mentioned in one article, of the larger foreign bodies causing appendicitis, straight pins are found most frequent-

ly.[29] Of course the literature records many other foreign body perforations.[28-36] Gunn surmised that intestinal perforation due to foreign bodies may be more common than supposed and in many cases may go unreported.[3] Certainly, then, sharp objects that may become lodged at, and/or perforate at any place along the intestinal tract, or large objects that may lodge at the pylorus and fail to navigate the duodenal loop or to cross the ileocecal valve deserve prompt action while in the stomach, and these points are what prompted us to proceed with the action in "Case One."

It has been recommended that "if the foreign body has a sharp edge or point and remains in a fixed position in the stomach or intestine on two examinations, surgical intervention is indicated to prevent complications."[25] However, this author recommends X-rays every four or five days, and "if the object is not fixed in one position, continued observation is believed to be in order."[25]

When "Case Two" arrived with two pins in his stomach it was decided to attempt the gastric suction routine with various positions. Despite placing the patient in various positions while receiving gastric suction, the pins were not removed; however, there was evidence by repeat X-rays that there was prompt progression of the pins.

In view of obvious progress, the watchful hospitalization routine, with follow-up X-rays, was decided upon as the form of therapy for this case. Various authors have recommended a high residue diet under these circumstances;[37] while others recommend only a regular diet.[23] The patient was given milk and bread hoping to coat the pins sufficiently with this high residue diet so that they would pass through the intestinal tract without getting caught. They completed their course through the alimentary tract the next day.

The careful observation routine has its proponents for sharp objects and is supported in the literature by various authors. As support for this principle it has been noted that 80%,[7] 81%,[8] to 90%[25] and 100%[23] of all types of foreign bodies that enter the stomach pass through the anus without problem.[34] Drs. Van Loon and Diamond reported that of 369 foreign bodies that entered the gastrointestinal tract, 85% passed spontaneously and of these only four had to be removed by laparotomy.[8] Others have reported the passage of large and/or sharp objects through the gastrointestinal tract.[25] Forty sharp objects reviewed by Delaney passed through the intestinal tract spontaneously without complications.[23] Lell reported a case of a child who swallowed a bundle of nails which passed without complication.[4] The author had occasion to follow a conventional fountain pen (separated into three components) all three parts of which passed through the entire gastrointestinal tract except for "the pin and bladder part" which got caught at the anal crypts and had to be removed digitally.

Consequently, with the support from the various points mentioned above, the "careful hospital watchful waiting"[3] with "bread and milk policy" was followed in the second case, especially since there was evidence of rapid progress of the pins.

Conclusions

1. The treatment of sharp objects in the stomach in the past has ranged from immediate laparotomy to long periods of watchful waiting.

2. It would seem that one of the safest methods of peroral removal of a small sharp foreign body is the placing of the patient in various positions while the patient receives gastric suction as was done in "Case Two."

3. Probably one of the safest methods of removal of a sharp foreign body (that is of ferrous material) from the stomach is by the utilization of a magnet. The magnet should be used when available but with recognition of potential problems even with this technique.

4. Despite the wide range of treatment available, it would seem that if suction and/or magnets fail and that if adequate equipment (including an "open" (direct) gastroscope, and an operating biplane fluoroscope) is available and someone trained in peroral endoscopy is available, that there is little doubt that gastroscopic removal (done promptly) is the procedure of choice.

5. Also, if suction has failed (in various positions) and if adequate equipment (and/or trained personnel) are not available in a comparatively remote district and if problems are to be had with consents (when problems arise) it would seem that a wider range of treatment is acceptable—ranging from watchful waiting to a laparotomy at the first suggestion of delay in the progress of the foreign body.

6. The routine of doing a laparotomy on any object with a sharp edge or point in the stomach or intestine that remains in a fixed position on

two roentgenographic examinations is acceptable in any case—especially when the examinations are made at intervals of four or five days.

7. In remote areas, where adequate equipment is not available, then a more aggressive approach to foreign objects in the stomach may be indicated, especially when there is the slightest suggestion that they are delayed, or may get caught or perforate somewhere along the gastrointestinal tract. This would include a small laparotomy incision with the hope of manipulating the foreign body into the esophagus, with removal at esophagoscopy as was done in "Case One," or manipulating a sharp pointed object through the wall of the stomach as suggested in the discussion; or if the above were not possible, then gastrotomy.

8. Based on conclusion #5 it appears that there is sufficient justification for a policy of a "careful hospital watchful waiting" (or even home observation with X-rays daily in an ideal home situation) when adequate equipment is not available, until, at least, there is a suggestion of delay in progress. This watchful waiting policy should include a high residue diet (or at least a regular diet), if no other specific contraindication is present, in order to coat the foreign body with the high residue produced.

Summary

The cases of two American Indian school boys who swallowed straight pins are presented. Different modes of therapy were used. Discussion is presented to support the different rationales of therapy.

A further recommendation is made for the use of suction with periodic changes in the position of the patient. A technique of forcing the foreign body antegrade (without opening the stomach) so that it can be removed by esophagoscopy is described.

References and/or reprints: Box 1565, Butler, Pa. 16001.



REPORTS

To The House of Delegates, Semiannual Meeting, September, 1968

BYLAWS COMMITTEE REPORT

Mr. President and Members of the House of Delegates:

The Bylaws Committee met on May 27, 1968 to consider various matters referred to it by the House of Delegates. In accordance with these mandates, the following recommendations are offered:

1. ADMISSION OF OSTEOPATHS TO MEMBERSHIP

Amend Article I, by adding new Section 6, to read as follows:

Section 6: The term "doctor of medicine" as used in these Bylaws is interpreted to include the degree "doctor of osteopathy" when such individual holds a valid license to practice medicine and surgery in Maryland."

2. RESOLUTION 3A/68, DEALING WITH WAIVER OF PHYSICIANS DEFENSE IN CERTAIN CIRCUMSTANCES BY THE COUNCIL

This suggestion, which was offered in Resolution 3A/68 and ruled out of order by the President, was referred to the Bylaws Committee with the consent of the House of Delegates for its consideration.

It would provide authority to the Council to waive the mandatory cut-off date for eligibility for physicians' defense.

The reason favoring adoption of such a bylaw amendment is that in cases of hardship, or where the physician, through no fault of his own, had forgotten to pay his dues in sufficient time to qualify for such defense, the strict rule might be relaxed.

The reasons against adoption of such an amendment include:

a. All members should be treated alike and no exceptions should be made because of an individual's laxity in ensuring that his dues payments are made on time and in accordance with the Bylaws.
b. Dues bills are sent out in late November or early December; in sufficient time for members to plan their financial matters and make payment by the deadline of January 31.
c. Less than 50 members are delinquent at the January 31 deadline.
d. If a physician suffers from financial hardship his dues can be excused for sufficient cause under Article III, Section 7, of the Bylaws; and legal defense would be provided to him if it is needed.
e. A physician could delay payment of his dues and make payment after an incident occurs or a suit is filed against him, if such a Bylaw change were made.
f. The Council has recently adopted the policy that the Bylaws in this area will be strictly interpreted and no exceptions will be made.
g. The decision as to provision of defense or exceptions to the Bylaws should not be left to the decision of a body which could conceivably be pressured either by the popularity of the member or other means into providing or making the exception to the Bylaws.

The Bylaws Committee, therefore, decided not to recommend such a change in the Bylaws at this time.*

3. PROVISION FOR AUTOMATIC CHANGE IN COUNCIL MEMBERSHIP AS MEMBERSHIP IN COMPONENT SOCIETIES CHANGE

This matter was also referred to the Bylaws Committee by the House of Delegates. It would provide

CENTRAL DISTRICT	NO. OF MEMBERS	TOTAL	NO. OF COUNCILORS AT PRESENT	NO. OF COUNCILORS UNDER PROPOSAL
Baltimore City	1541			
Baltimore County	267			
Harford County	49	1857	11	10
EASTERN DISTRICT				
Caroline County	7			
Cecil County	21			
Dorchester County	17			
Kent County	13			
Queen's Anne's County	4			
Somerset County	6			
Talbot County	32			
Wicomico County	74			
Worcester County	8	182	2	2
SOUTH CENTRAL DISTRICT				
Montgomery County	459			
Prince George's County	196	655	5	4
SOUTHERN DISTRICT				
Anne Arundel County	110			
Calvert County	6			
Charles County	10			
Howard County	16			
St. Mary's County	16	158	2	2
WESTERN DISTRICT				
Allegany County	81			
Carroll County	50			
Frederick County	60			
Garrett County	5			
Washington County	92	288	2	2
TOTALS		3140	22	20

for automatically changing the composition of the Council as the total Active and Forty-Year membership in the various Councilor Districts increases or decreases.

In order to consider this proposal, the Bylaws Committee had prepared for it the following report on the present composition of the Council as compared to the Active and Forty-Year membership in each District. the closest multiple that could be used to arrive at the closest figure for Council composition as it presently exists was the following:

One Councilor from each Councilor District and One Councilor for each 200 Active and Forty-Year Members or major fraction thereof.

This would result in changes in only two of the districts. *(See Table at left)*

All figures as of December 31, 1967; includes Active and Forty-Year members only.

Any proposed change in the Bylaws would require that each of two districts lose a councilor. It is, therefore, proposed that no change in the Bylaws be effected at the present time. Instead this will be carried as a continuing item on the Agenda of the Bylaws Committee; and a re-evaluation made at each meeting of this group.

It is conceivable that both the Central District and the South Central District will increase in sufficient size by December 31, 1968, so that the Council composition will be in complete balance based on the formula proposed. (In the Central District an additional 44 members are needed; in the South Central District an additional 46 are needed.)

At the appropriate time, a bylaw amendment will be prepared and offered* to the House of Delegates for adoption.

The Bylaws Committee cautions the House of Delegates that the composition of the Council may become unwieldy. There is a total membership of 36 now on the Council (22 Councilors, 7 Officers, 4 Committee Chairmen, 3 AMA Delegates).

Respectfully submitted,

DeWitt E. DeLawter, MD
Vincent J. Fiocco, MD
Edmond J. McDonnell, MD
Charles F. O'Donnell, MD, *Chairman*

* This Committee was not "directed" to report such amendments, hence, it has the power to kill them. The House has no power to adopt amendments, the Committee to the contrary notwithstanding.

REPORT OF THE DELEGATES TO THE AMA

Mr. President and Members of the House of Delegates:

Your three Delegates and the Senior Alternate Delegate to the American Medical Association's House of Delegates attended all sessions of the House during its meeting June 16-20, 1968. In addition, one of your Delegates served on Reference Committee A. These committees consider various items referred to them and make recommendations to the AMA House of Delegates for its consideration and action.

As has been the custom for several years, each of the members of the Maryland delegation attend meetings of the various Reference Committees and listen to the discussion so as to brief all other members of the Maryland delegation as to the basis for many of the recommendations of the Reference Committees to the AMA House of Delegates. Inasmuch as there are usually more Reference Committee sessions than there are members of the Maryland delegation, individual Faculty members (and in some cases other alternate delegates) have kindly volunteered to assume this responsibility. This is most appreciated by the Maryland delegation.

Also, as is usual, various items considered by the AMA House of Delegates are referred to appropriate Faculty Committees for their information and whatever action, if any, they consider appropriate.

Perhaps one of the most disturbing items of information received by the AMA House of Delegates was the fact that there are some financial uncertainties ahead for the AMA. These are created, primarily, because of IRS regulations that taxes must be paid on "non-related business income" which means that taxes will be assessed the AMA on all advertising revenue received by its various publications. This question is still under discussion at the present time.

A complete list of actions of the House is as follows:

Summary

The House was in session for 13 hours and 42 minutes, ending at 10:50 a.m. June 20. It faced 143 items of business, including 84 resolutions; 39 reports from the Board; 7 from the Council on Constitution and Bylaws; 4 from the Council on Medical Education; 5 from the Council on Medical Service; 2 from the Judicial Council; and 2 special reports.

Fourteen of the items were accepted or approved for information; 62 were adopted, approved or accepted; 31 were referred to the Board and/or a Council or Committee; 20 were replaced by substitute resolutions; 10 were rejected; 2 were postponed to the next meeting of the House; 1 was tabled; and 3 were withdrawn.

Elections

Gerald D. Dorman, New York, was named President-Elect by acclamation, after receiving nomination and 16 seconds from the floor.

Carl A. Lincke, Ohio, was elected Vice President, also by acclamation.

Walter C. Bornemeier, Illinois, and Russell B. Roth, Pennsylvania, were re-elected by acclamation to their respective posts as Speaker and Vice-Speaker of the House.

Four trustees were elected: L. O. Simenstad, Wisconsin, succeeding himself; and Raymond T. Holden, Washington, DC; John M. Chenault, Alabama; and John R. Kernodle, North Carolina.

Walter H. Judd, Washington, DC, was elected by acclamation to succeed himself on the Judicial Council.

Robert B. Hunter, Washington, was elected to the Council on Constitution and Bylaws.

Francis L. Land, Washington, DC, and E. Bryce Robinson, Jr., Alabama, were re-elected by acclamation to the Council on Medical Education.

Burns A. Dobbins, Florida, and Drew M. Petersen, Utah, were re-elected by acclamation to the Council on Medical Service; and W. B. Hildebrand, Wisconsin, was elected to fill the remaining two-year term vacated by John R. Kernodle, who was elected to the Board.

Eliminating Discrimination

The House approved a resolution that "The bylaws of the AMA be amended to provide that in addition to receiving 'appeals filed by applicants who allege that they, because of color, creed, race, religion or ethnic origin, have been unfairly denied membership in a component and/or constituent association,' determining facts

and reporting its findings to the House of Delegates, the Judicial Council shall, if it determines the allegations are indeed true, admonish, censure or, in the event of repeated violations, recommend to the House of Delegates that the state association involved be declared to be no longer a constituent association of the American Medical Association."

The Council on Constitution and Bylaws will draw up the necessary new wording for the bylaws for action at the next meeting of the House.

In addition, a joint statement of the AMA and the National Medical Association was contained in a Board report accepted by the House for information. The statement pointed out that the number of Negro physicians, although not specifically known, is not in proportion to the Negro population and that the difficulty in finding more than a few promising candidates for medical school "reflects cultural and educational problems stretching back to the quality of instruction in the secondary and primary grades and that of pre-school training in the home."

The AMA and NMA concluded that "genuine solutions to the problems of increasing the supply of Negro physicians must emanate through improved curriculums, better teaching and specialized courses of training at all school levels for promising Negro students."

Also urged by the two associations were that: "Special college courses be developed for such students. Additional scholarship aid be established at both the college and medical school level for Negro students. . . . Summer programs of special study be arranged for all disadvantaged students about to enter medical school. . . . All medical schools encourage members of their faculties to sponsor special projects involving Negro high school students in laboratory work or other enlightening pursuits to enrich their experiences. All medical societies, medical schools and related groups expand their careers programming with students, parents and guidance counselors at schools of all levels. . . ."

Health Care Costs and Financing

A report of the Committee on Health Care Financing, transmitted by the Board, was accepted for information. It included background on the committee's findings and set forth these directions for the future:

"Adequate health care should be available to all who need it. Recent scientific advances have served to vastly increase the demand for medical services and to increase health care expenditures. Methods of financing health care must aid all individuals to achieve the health services they need. Voluntary programs to finance the costs of health services must accommodate to continuing changes and growth."

Proposals under study by the committee include a community fiscal agency for health services, "not as a competitor for existing health insurance plans, but to complement those efforts and stimulate greater achievement;" and "income tax credits for the premiums paid for adequate health insurance . . . an effective and feasible method of encouraging maximal participation in voluntary comprehensive health insurance programs."

A resolution was adopted that "the principle of graduated income tax credits for premiums paid for adequate health insurance be adopted as approved policy of the AMA."

Another adopted resolution urged all state and local societies "to act swiftly and firmly in all instances of known exploitation and excessive charges for health care that may occur in their jurisdictions."

A resolution referred to the Board called for a program by the AMA of "defining, explaining and reporting the many categories of health care expenditures; analyzing health care cost and expenditure data developed and reported by other sources; and providing . . . information on health care costs which can be used to place the true costs of medical care in proper perspective with the public."

A Board report on the economics of health care, adopted by the House, pointed out that the Board "has approved a committee recommendation that a technical evaluation of the full potentialities of the AMA in the field of economics of health care be carried out by a small advisory group of competent, nationally recognized economists. It is expected that this will be done promptly."

In the area of reducing costs to patients, the House adopted a resolution that "the AMA endorse the principle of voluntary health insurance coverage for out-patient X-ray and laboratory services acceptable to the hospital and its medical staff wherever performed prior to a scheduled hospital admission;" and adopted another resolution that "all insurance companies and fiscal intermediaries" adopt and authorize the use of standard forms in conjunction with a single hospital admission to save physicians' time and expense.

With respect to physician time, the House recognized "the excellent contribution made to the continuing education and improvement of physicians' knowledge by many methods of medical meetings, scientific conferences and critical review of clinical experience," but pointed out that these must "be contained within the physician's available time" and urged "continued experimentation in methods that would . . . conserve the physician's time and thus improve the quality of patient care."

Legislation and Relationship with Government

Regarding comprehensive health planning, the House adopted a Board report recommending that "the House of Delegates urge those states which have not held informational conferences on the subject to conduct orientation conferences in order to reach a greater number of leaders at the local level." The report pointed out that, "The Department of Hospitals and Medical Facilities has mailed periodically to each state medical association packets of pertinent references on PL 89-749 and PL 89-239 . . . and . . . the Board has authorized development of a 'Handbook on Prototypes of Community Planning for Health Services' based in part on field surveys."

Also adopted was a Council on Medical Service report on comprehensive health planning which recommends that "The AMA and the constituent and component societies give unstinted, diligent attention to the process of comprehensive health planning which, at present, places priority on local initiative and decision-making, and that the AMA at all levels endeavor to assure through all appropriate means, a system of checks and balances so that state and area planning agencies are not given authority to subordinate local planning efforts and dictate local decisions on health planning."

Two resolutions concerning comprehensive planning were combined to state the House's will that "medical societies encourage the organization of local health planning councils without the assistance of HEW grants."

The House also expressed its will that "The society should use some mechanism such as a nonprofit corporation or other entity, separate from the society itself and served by an independent administrative staff, where possible, to avoid direct operational involvement of the medical society as a body."

A Council on Medical Service report adopted by the House pointed out, "There are no easy, black-or-white solutions to this dilemma. With government increasingly involved in research and experiment in the delivery of

health services and payment for care, we cannot ignore government programs. On the other hand, the multiplicity of programs and approaches at the national, state and local level precludes blanket endorsement of any given level of involvement. The Council therefore recommends that this House make it clear that medical societies *may,* after mature consideration, legitimately take part in such programs . . . and that it should trust to the good sense of the individual state and county societies to recognize the serious import and the need for careful study before deciding on such a step."

To strengthen the AMA's continuing liaison with the federal government on matters of health legislation, the House adopted a statement that because "the private practicing physicians are the best qualified group in matters pertaining to health services," the AMA should "request the Secretary of HEW to continue to solicit the advice and counsel of those practicing physicians designated by their medical associations at the local, state and national level in formulating future plans and programs and in modifying existing programs, in order to provide the best quality health care to the people of the United States."

Three resolutions were introduced objecting to the government's support of group practice, particularly the prepayment type. They were combined into one substitute, "Resolved, that the AMA continue to espouse the private, fee-for-service practice of medicine; and be it further resolved that the AMA strongly disapproves of the provision of funds by the federal government for subsidizing any one form of organization of medical practice."

In that connection, the House referred to the Board a resolution that the Board set up "a national forum on the solo practice of medicine for the purpose of examining the need for this type of physician care, public preference between solo and group practice and how solo practice should be encouraged."

A resolution was adopted that the Board attempt to change the terminology in the Medicare "Explanation of Benefits" form to eliminate the confusion and criticisms which now exist. Another, referred to the Board, sought to have extended care facilities defined as residences so physicians may bill patients directly for portable X-ray services performed there.

In addition, the House reaffirmed "previous policies requesting that all efforts be made to eliminate recertification requirements under" Medicare and called on the congress "to amend the laws and regulations pertaining to PL 89-97 to specifically permit direct billing to all Title 19 recipients."

The House also resolved that "The Board . . . take appropriate action seeking the establishment of a separate Department of Health headed by a Doctor of Medicine."

A resolution proposed that congress establish within its control a "Committee on Rules and Policies of Federal Administrative Agencies" whose "responsibility it will be to review rules and policies promulgated by federal administrative agencies to determine that (they) are in accord with the legislative intent of the congress." It was adopted in principle and referred to the Board and the Council on Legislative Activities.

The House voted to continue the AMA's own educational program on smoking and health rather than become a formal sponsoring member of the Interagency Council on Smoking and Health.

Finally, in this category, the House resolved to call to the attention of state governors and other state and local officials "that the maintenance of medical treatment facilities and the care of all patients and hospital personnel in the event of a disaster is of prime and basic importance" and that "preliminary planning to provide such protection be a part of every disaster program."

Manpower

In response to a report from the Board, a Council on Health Manpower was created by the House, to assume the functions and responsibilities of the former Committee on Health Manpower and the former Commission on Relationships Between Medicine and Allied Health Professions and Services.

With respect to relationships and negotiations between the AMA and the osteopaths, the House accepted for information a Board report which stated, "In the absence of cooperative leadership on the part of the practicing osteopaths and osteopathic educators, accomplishments by the AMA are rendered difficult. Such leadership was forthcoming in California, and is now needed elsewhere. When this osteopathic leadership is developed, the AMA stands ready to cooperate to its utmost."

The House approved a Board report reviewing studies of the status of foreign medical graduates in the United States and directing the new Council on Health Manpower to take the steps necessary to complete plans for the organization and financial support of a commission, to be established outside of government, to coordinate fully all of the issues and activities involving FMG's.

Education, Medical and Allied

The House approved a Board report urging "that the constituent and component societies of the Association make every effort to insure that additional financial support for medical schools be obtained from all available sources. The Board and the Council (on Medical Education) further urge that all physicians individually recognize their debt as graduates of medical schools . . . by contributing regularly and generously to the financial support of medical schools through the 'Fund for Medical Schools' project" of the AMA-ERF and other appropriate channels.

"Essentials of Approved Residencies" pertaining to residencies in general practice, physical medicine and rehabilitation, psychiatry and anesthesiology were revised.

The House referred to the Council on Medical Education a resolution protesting proposed changes in the Essentials for Accredited Schools of Medical Technology by the American Association of Clinical Pathologists which would eliminate approved schools of medical technology on the basis of size; and referred to the Board a resolution that osteopathic physicians be admitted to AMA-approved hospital internship and residency programs under certain circumstances.

Also referred to the Board was a resolution to establish a joint commission on accreditation of nursing schools, with participation by the AMA, AHA, ANA and National League for Nursing.

The House resolved to urge the Board "in its selection of nominees for the Council on Medical Education to give full recognition to the importance of non-university affiliated hospitals in providing effective educational experience;" and referred to the Board and its Council on Health Manpower a resolution that the AMA "establish guidelines for the benefit of constituent and component organizations in dealing with new, as well as emerging paramedical disciplines as they come into being."

Another resolution referred to the Board related to the JCAH ruling with respect to the use of externs, under proper supervision, for recording history and physical examinations on patients' charts in non-university affiliated hospitals.

Infant Mortality

The House approved a statement on infant mortality prepared by the Committee on Maternal and Child Welfare of the Council on Medical Service and submitted by the Board. The report included a number of recommendations, among which were these:

"Recognizing the fact that unfavorable environmental and socioeconomic factors as well as medical factors are involved in infant mortality, the medical profession should support all constructive community efforts for the improvement of living conditions among the needy.
"The AMA should inaugurate and support programs of health education, including good maternal and child health practices, family life and sex education and the appropriate use of health care resources.
"The AMA should give impetus to broad and inclusive programs for the care of the unwed mothers."

With respect to statistics, the AMA "should provide leadership in a program to obtain national uniform registration statutes for births and deaths . . . promote efforts through the World Health Organization and other authoritative bodies to bring about uniform registration requirements and . . . truly comparable statistics . . . and support educational programs directed toward physicians concerning the value of accurate uniform reporting."

Regarding quality and availability of care, "State and component societies should evaluate existing maternal and child care resources and take leadership in the expansion and development of programs for delivering services in locations found to be deficient."

The report urged that, where feasible, "perinatal death studies be conducted on a community-wide basis or by a hospital staff or medical group for the purpose of reducing infant mortality and providing educational programs;" and also recommended that the AMA "stimulate research into the cause and possible prevention and control of 'crib deaths' of infants."

Transplantation and General Thoughts on Patient Care

A Judicial Council report was adopted on "Ethical Guidelines for Organ Transplantation." One of several important guidelines was, "When a vital, single organ is to be transplanted, the death of the donor shall have been determined by at least one physician other than the recipient's physician. Death shall be determined by the clinical judgment of the physician. In making this determination, the ethical physician will use all available, currently accepted scientific tests."

A Council on Medical Service report on automated multiphasic screening, approved by the House, pointed out that tests used in "a multiphasic screening program should be relatively simple to administer, easy to interpret, relatively inexpensive and require little time to perform." All such screening programs should be subjected to the five criteria suggested by the former National Commission on Chronic Illness: reliability; validity; yield of information; cost; and acceptance by physicians, individual laymen and the community.

The House resolved, in connection with proposals for a national compendium of approved drugs, that "present quality standards imposed voluntarily by the American pharmaceutical industry should not be abridged or usurped by any federal agency, and . . . any drug compendium devised should be made available solely as a reference source of information."

The Board was directed by the House "to evaluate the practicality and feasibility of establishing a national health data banking system and to evaluate other aspects of data processing related to the practice of medicine."

The House adopted a Board report recommending AMA support for the use of the Slow-Moving Vehicle Emblem developed by Ohio State University for all vehicles, tractors, construction equipment or horse-drawn vehicles moving less than 25 miles per hour.

By adopting a Board report, the House voted to "participate in a program of planning and action with other organizations concerned with architectural barriers to the handicapped" and requested state and county medical societies to encourage their members to become active in helping to alleviate such barriers.

The House resolved to continue AMA "efforts to safeguard and inform the medical profession and the public with respect to the treatment of obesity."

It also referred to the AMA's policy on chiropractic and urged state and local medical societies "to formally adopt the AMA Policy Statement on Chiropractic, or a somewhat similar expression" and "to alert the general public to the health hazard posed by the cult of chiropractic."

Hospitals

The House approved a Board report stating that communication with hospital Boards of Trustees has been supplemented by increasing the circulation of the AMA's publication "Medical Staff-in-Action" to include physician-hospital relationship committees of state and local medical societies and of state and local hospital associations.

A resolution was adopted that "state medical associations and state licensing and certifying agencies establish and maintain close surveillance of the certification and accreditation problems of small hospitals," which generally are not acceptable for Medicare patients, thereby denying benefits of the law to many persons among the rural aged.

Noting that new Standards for Hospital Accreditation are under way by the JCAH, the House resolved that the Board "direct the AMA Commissioners of the JCAH to arrange for the tentative draft of the new standards to be submitted to individual state associations for comment before final adoption."

The House again urged "that adequate representation of the medical staff on the voting membership of the hospital's governing body is the most effective mechanism for assuring a working communication, provided that the physicians serving on the governing board be nominated by the medical staff of the hospital."

Regarding use of paramedical personnel, the House recommended to the JCAH, AHA and its state and local chapters and to hospitals and other related facilities "that the practice of medicine . . . be preserved as the responsibility of the physician and that paramedical personnel not be placed in the position of practicing medicine whether by consent, design or contract;" and recommended "to the state and county medical societies and hospital staffs that they call attention to the dangers of contractural agreements which remove the services of paramedical personnel from the supervision of the physician."

Public Relations

A Board report was adopted that reproduced a statement by the AMA's public relations counsel, Mr. Philip Lesly. Titled "Considerations for Coping with the New Climate Involving Health Care," the statement pointed out many problems faced by the medical profession and urged that the "foundations of public relations for the profession" must be:

Practical—viewing each circumstance in terms of the consequences of any action or position.

Positive—AMA should be the leader of action and thought on medicine; not in the position of reacting to the actions or statements of others.

Anticipatory—AMA should be the master of change rather than its victim.
On the Initiative—fostering balanced, informed, widespread coverage of medicine and health care rather than to matters initiated by others.
Augmented by voices of respected laymen.
Selective—concentrating on activating AMA's programs and priorities, with full knowledge it will mean passing up many things that appear to need attention but are not part of the over-all constructive plan.

AMA Financial Status

The House accepted for information a Board report concerning "the fiscal uncertainties which lie ahead" for the AMA. It is anticipated, the report said, "that a substantial increase in the budget of the AMA will be necessary within the next few years if the AMA is to fulfill its mission. Major items such as the cost of printing and paper are rising sharply and the pressure of inflation has greatly increased the cost of providing AMA's normal services."

The report stated that the tax effect of the IRS regulations is not known at this time on the AMA's gross income of approximately $13 million annually from advertising in its publications before deduction of costs and allowable expenses.

The report pointed out that the Board "is not recommending an increase in dues . . . at this time, because it wants additional information regarding various matters affecting our financial situation before reaching such a decision."

The House adopted a resolution urging "positive action to encourage reduction of the expenditures of this Association" by "requesting the Board . . . to continue to take action to reduce, to the extent possible, the extraneous activities financed in whole or in part by the AMA" at all meetings of the House, councils, committees etc.; and requesting the Board to continue "to make recommendations as to the consolidation or even abolishment of councils and committees" whose reason for creation may no longer exist.

Additional Actions

Association bylaws were amended to provide a change in the name of the Section on Miscellaneous Topics to the Section on Special Topics; and to change the name of the Section on Laryngology, Otology and Rhinology to the Section on Otorhinolaryngology.

Changes were approved in the procedures for introduction of resolutions and other business, as well as the withdrawal of resolutions both before and after consideration by a reference committee.

The term of office of the President was established as ending with the inauguration of a new President, and the Vice President's term was changed to coincide with that of the President with whom he serves.

The Council on Constitution and Bylaws was asked to study Robert's "Rules of Order," revised, and Sturgis' "Standard Code of Parliamentary Procedure" (which includes reference committees) and report at the Annual Convention, 1969, on which should govern the procedures of the House.

The House accepted for information a Board report estimating "for the year 1967" the "total cost of professional liability insurance coverage for physicians and surgeons, and the total amount that eventually will be paid to satisfy claims originating from medical services rendered in that year." Two other reports on professional liability were considered by the House.

The House agreed not to change present policy with respect to allowing non-member physicians to attend the scientific sessions of the AMA without registration fee.

The House stood in silent tribute to six members of the House and/or officers who had died since the previous Annual Convention; and also in honor of 19 military medical officers who have died in Vietnam.

Dr. Irvine H. Page, director of research (emeritus) of the Cleveland Clinic Foundation was the first winner of the Dr. Rodman E. Sheen and Thomas G. Sheen Award, established to honor "the outstanding doctor of medical science in the United States for each year." The award was a plaque and $10,000 cash in recognition of his scientific research, especially in the fields of hypertension and other cardiovascular diseases. The award was established by the will of Thomas G. Sheen, Atlantic City, N.J., business man, and was named for Sheen and his younger brother, a physician whose medical career was cut short by an accident and illness.

Respectfully submitted,

Robert vL. Campbell, MD
J. Sheldon Eastland, MD
Russell S. Fisher, MD

POLICY AND PLANNING COMMITTEE

Mr. President and Members of the House of Delegates:

The Policy and Planning Committee had two items referred to it by the House of Delegates, in April, 1968. A report on these two matters is as follows:

1. 100% Membership in the Woman's Auxiliary:

The Woman's Auxiliary had proposed at the 1968 Annual Session that Faculty members' dues bills include an amount to pay for Woman's Auxiliary membership for all Active, Forty-Year and Emeritus Members' wives, plus widows of members, thereby creating 100% membership in the Woman's Auxiliary. The Policy and Planning Committee met on May 23, 1968, to discuss this and other items.

The Committee was unanimous in its praise of the work being done by the Auxiliary and many suggestions to accomplish the objective as outlined by the Auxiliary were discussed. It was proposed, for instance, that a set amount each year be assigned for Auxiliary work, with Faculty dues being increased to accomplish the assignment of funds for this purpose.

In Baltimore County, for instance, the County Medical Association pays over $5.00 per County Association member to the Auxiliary; with Auxiliary members being billed separately for their National and State dues for those who wish to join. This seems to be satisfactory to the County Medical Association members as well as to the Auxiliary members.

At present, $1,000 per year is included in the Faculty's budget and is paid to the Auxiliary for its use as it sees fit. In addition, considerable staff effort and time is devoted to assisting Auxiliary officers and members in the accomplishment of their endeavors.

Some of the members of the Policy and Planning Committee pointed out that some counties do not have organized Auxiliaries; and that in some areas two or more counties have banded together to form an area-wide auxiliary chapter. The Committee considered this and other ramifications such as forcing a component society of the Faculty to have a formal auxiliary chapter in that county. This would seem to be undemocratic, particularly when the component society involved may have elected not to approve the formation of an auxiliary chapter in that county.

In addition, the concept of 100% membership, as proposed, would force membership on some physicians' wives who may not wish to be an Auxiliary member. This, again, would appear to be undemocratic.

The Policy and Planning Committee, therefore, and after considered discussion, recommends adoption of the following by the House of Delegates:

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland favors 100% membership in the Woman's Auxiliary on a voluntary basis, but is of the opinion that a statewide assessment or dues increase creating involuntary membership would be unwise. Component Societies are encouraged to consider this matter individually, in order to arrive at the most equitable arrangement for each group.

2. *Resolution 4A/68, Incorporation of Self-Employed Persons*

This resolution was referred to the Policy and Planning Committee by the House of Delegates, such recommendation having been made by the Reference Committee. A subcommittee was appointed to hear all viewpoints on this proposal; and the full committee met on Thursday, July 25, 1968, to consider the report of the Subcommittee. The report of the Subcommittee was adopted unanimously by the full Committee. It reads as follows:

"The American Medical Association has no position for or against incorporation of self-employed professionals. Since 1957 the AMA has had no objection to corporate group practice provided the corporation is controlled only by physicians. If physicians do incorporate, it is imperative that no lay person will ever be able to obtain a stock interest.

"It was ascertained that the four characteristics of a corporation as determined by the IRS were in fact only regulations and not law; that is, centralized management, continuity of life, limited liability, and free transferability of interest.

"Two recent court cases are of interest in this context. The Empey case in which a member of a corporation of lawyers applied for a refund of taxes based on lesser taxable income as an incorporated entity was one. IRS disallowed the refund and the case was appealed to the Colorado State Supreme Court. The Court decided in Empey's favor, stating that the IRS regulations were not based on statutory enactments and represented an attempt by the IRS to usurp the legislative function. The IRS has appealed this case.

"In the O'Neill case in Ohio (Ohio has a statute permitting incorporation of self-employed persons) the Ohio Supreme Court found the IRS was trying to perform a function of Congress. To date, the IRS has not appealed this decision.

"The Florida Professional Service Corporation Act (a statute permitting incorporation of self-employed persons) was discussed and pointed out as an ideal law. This act covers those engaged in any type of personal service which requires licensure. Self-employed persons in Florida and most states are personally liable as well as the corporation. In Colorado, under a rule of court, liability may be limited if a liability policy is purchased in an amount set by the court.

"Various tax advantages were pointed out, such as pension plans, capital improvement reserves, lower overall income taxes, group insurance benefits and stock options.

"It was determined that at the present time, physicians in Maryland are not specifically prohibited from forming corporations, but that no safeguards, such as mentioned, exist on their format.

"It was felt that the opportunity to secure tax benefits by achieving corporate status should not blind professional men to other factors not related to tax considerations. An important consideration is the compatibility of individuals. Another important factor is the ability of individual members to disassociate themselves from thinking and acting as partners—failure to do so would almost certainly result in the creation of a superficial corporation and non-recognition by the IRS.

"It was ascertained that 35 states at present have laws which permit incorporation of self-employed persons. Nothing in these acts prevents a single individual from incorporating.

"The Subcommittee feels that at present the situation is in a state of flux and there is no certainty as to what Congress may do if the IRS is finally defeated in its efforts to discriminate against the professional man. It feels that it is the responsibility of each member to determine for himself the advisability of self-incorporation. If self-incorporation is attempted, there must be complete control by licensed physicians and safeguards must be built in to prohibit any inroads by lay people. Liaison with other professional groups should be initiated and maintained."

The Policy and Planning Committee, therefore, recommends to the House of Delegates that the following current policy of the Faculty be rescinded:

"The Committee is unanimously of the opinion that the Medical and Chirurgical Faculty should not support any such legislation and so recommends to the House of Delegates.

"Further it feels that the Faculty should not support any physician or groups of physicians who are seeking to change the Medical Practice Act with regard to tax advantages."

(Adopted, Semiannual Session, September, 1962)

and that the following new policy be adopted:

1. The Medical and Chirurgical Faculty should not initiate any legislation in this field at present.
2. The Medical and Chirurgical Faculty should not oppose any efforts of physicians or groups of physicians to incorporate, provided that ownership and management is exercised solely and completely by licensed physicians.
3. The Medical and Chirurgical Faculty should initiate and maintain liaison with other professional groups to keep abreast of further developments in this area.

Respectfully submitted,

ARTHUR T. KEEFE, JR., MD, *Chairman,* Kent County
J. THOMPSON B. AMBLER, MD, Talbot County
CHARLES BAGLEY, III, MD, Wicomico County
NEVILLE A. BARON, MD, Worcester County
A. N. BARR, MD, Somerset County
WILBUR N. BAUMANN, MD, Dorchester County
LEON W. BERUBE, MD, St. Mary's County
RICHARD T. BINFORD, MD, Washington County
KATHERINE H. BORKOVICH, MD, Baltimore City
ROBERT J. DAWSON, MD, Allegany County
RICHARD L. FRUTH, MD, Frederick County
GEORGE E. GROLEAU, MD, Howard County
WILLIAM A. HOLBROOK, MD, Prince George's County
JOHN C. HYLE, MD, Baltimore County
FREDERICK J. HATEM, MD, Harford County
J. PARRAN JARBOE, MD, Charles County
HERBERT H. LEIGHTON, MD, Garrett County

Julius Loebl, MD, Anne Arundel County
Herman C. Maganzini, MD, Montgomery County
Rolando R. Najera, MD, Cecil County
William R. O'Rourke, MD, Carroll County
Harold B. Plummer, MD, Caroline County
John R. Smith, Jr., MD, Queen Anne's County
Hugh W. Ward, MD, Calvert County

ex officio:

Arthur G. Siwinski, MD, President
Russell S. Fisher, MD, President-elect
William A. Pillsbury, MD, Secretary
Karl F. Mech, MD, Treasurer
John F. Schaefer, MD, Council Chairman
Manning W. Alden, MD, Council Vice-Chairman

REFERENCE COMMITTEE REPORT

Mr. President and Members of the House of Delegates:

The Reference Committee met on Thursday, August 15, 1968, to consider the resolution referred to it by the House of Delegates; as well as two resolutions introduced by individual members of the Faculty. The meeting was publicized through the mailing of a postal card to all Faculty members on July 26, 1968, advising them of the meeting; as well as through the Executive Secretary's Newsletter in the June and July issues of the Maryland State Medical Journal.

Individual letters were addressed to parties who held a particular interest in the subjects under discussion inviting them to attend the session and to express their viewpoints on these matters.

The Reference Committee was gratified by the rather large attendance at the meeting, even though it was in the midst of summer vacation schedules.

As usual, *the motions made will be on the resolution itself, and not on the recommendation of the Committee.*

Resolution 6A/68

Submitted on: April 17, 1968
Introduced: The Council
Subject: Participation in Maryland's Title XIX (Medicaid) Program

Whereas, Physicians have traditionally given of their services freely and willingly to those unable to pay for them; and

Whereas, The United States Congress has determined that physicians will be paid for their services rendered to those eligible under Title 19, PL 89-97, and has issued regulations stating that this must commence on July 1, 1967; and

Whereas, Many States, including Maryland, are reluctant to provide the needed funds for these services, services which have been provided over the years at no cost to the government; and

Whereas, The United State Department of Health, Education and Welfare has decreed:

Para. D-5330 - 2. Handbook of Public Assistance Administration

"Participating practitioners include sufficient members of each profession, and a proportionate number of practitioners qualified for specialty practice within professions, so that the items of medical care and services included in the plan are available to eligible persons at least to the extent they are available to the general population. As a minimum, the participation ratio determined separately for each profession, and for specialties within a profession, should be approximately two-thirds of such practitioners in the State."; and

Whereas, Determinations as to the services, persons covered, and the rules under which medical care is provided are being reached without adequate consultation with the providers of the services; and

Whereas, Inadequate information provided to Legislators has led the public to believe there was abuse of the program by physicians—but interestingly enough no criticism, charges or other allegations against other providers of health services; and

Whereas, The Medical and Chirurgical Faculty of the State of Maryland believes it was not the intent of the United States Congress to continue to have health care provided our needy citizens on a hit or miss basis; now, therefore, be it

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland hereby pledges the physicians of Maryland to provide health care to needy and near-needy citizens without payment whatsoever; and be it

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland believes that minimum standards provided for in Federal Legislation and Regulations; as well as a requirement that annual improvements be made in programs offered by the various states, are all realistic; and be it

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland urges its members to provide needed health services to needy and near-needy citizens BUT THAT PHYSICIANS SUBMIT NO BILLS FOR THESE SERVICES TO THE STATE HEALTH DEPARTMENT UNTIL SUCH TIME AS ADEQUATE CONSULTATION, ADMINISTRATION AND PROVISION FOR PAYMENT IS ARRANGED WITH THE PHYSICIANS OF MARYLAND; and be it

Resolved, That by this action it is known that physicians are not participating in the Title 19 program as it presently exists in the State of Maryland; and be it

Resolved, Copies of this declaration be sent to all those officials concerned with the operation of the Program.

At the Faculty's Annual Session, on Friday, April 19, 1968, this was discussed at considerable length. At this time, there seemed to be some question as to the language used in the resolution, as well as what was meant by the non-submission of bills for services rendered to Medicaid patients. We think it is important enough to repeat, in part, some of the comments taken from the verbatim transcript of that Annual Session.

DR. SPEED: There are a couple of points, I think, we should talk about, and perhaps have some discussion before we come down to the finer points of this resolution. The third resolved, which is the thing I think we should attract our attention to right now, in capital letters says, "but physicians submit no bills for these services to the state health department," and so on. I think we first must decide whether it is the intent of the House of Delegates to instruct or to encourage and we can't really instruct but to encourage the physicians of the State of Maryland to not participate in the present or proposed title 19 program or the Maryland Medical Assistance Program and, if this is so, then I think we'd better ask ourselves whether this resolution as proposed by the Council is really the correct one.

Let me assume for a moment anyhow that you do

agree that some type of action is needed in this particular area. I think we must decide after a year and a half to two years, whether or not we wish to yield a bigger stick than we've been—wield, rather, a bigger stick than we've been wielding before, and if so, is this the right way to do it.

As most of you here know, I think, the Professional Medical Services Committee has been working in the area of trying to get Usual, Customary, and Reasonable fees through the State Health Department in the Title 19 program, and all the Maryland Medical Assistance Programs. We have gotten agreement at least verbally, and I believe also in writing, that, in principle, this is agreed upon by those financially responsible the agencies financially responsible. Their excuse always comes back to the point that there is no money and that the legislature votes no money, and hence they must operate within the budgetary controls placed on them, so that they make decisions sometimes unilaterally as to how physicians will be paid.

To brief you again, as you know, the House—the office visits, home and office section, is reasonably well taken care of and they are making payments in this area, the problem rises mostly in in-hospital and outpatient care throughout the state. Now, if we, for instance, accept the resolution as it is offered now, we are asking a very small segment of physicians in the State of Maryland to, well, really go on relief because they cannot afford to not turn in bills to the State Health Department when 90 to 95 Percent of their practice is involved with the patients under these programs.

I think what we're trying to say here, what the proposers of this proposal are trying to say is that really two-thirds of the physicians in the State of Maryland are not willing to participate in the present of proposed Medicaid program, but I don't think we're getting that point across if we use the present resolve which is going to hurt a very small minority but a very important group of physicians in the State of Maryland.

I wonder if some would discuss as a possibility that we consider a poll of the membership with some kind of statement that, and I've just quickly done this and I'm sure it can be greatly improved upon, which would be to circulate a poll stating—asking whether the physician who is being polled agrees that "this is to certify that I will not participate in the medical—in the Maryland Medical Assistance Programs until Usual, Customary, and Reasonable fees are paid by the financially responsible agencies."

Now, let's talk about what the word participate means. This does not mean that if you do not participate that you're not going to take care of patients because, of course, this I don't think anybody could do even if he were asked not to do it. What it does mean by not participating would be that you're not participating from the standpoint of agreeing to accept substandard fees for services that you're rendering to a supposedly financially responsible agency, and I think these are the two points that the House of Delegates must consider now. Do you want to do it in this manner, or do you wish to consider the resolution as proposed to you by the Council and, at the moment, by the way it is worded, I would be opposed to the resolution by the Council, but I am heartily in agreement with the intent of this proposal.

I also would be concerned if we delay this action. We have done this every six months in a sense by going on record stating that we will accept Usual, Customary and Reasonable fees in dealing with third party programs, and this is again what we would be doing I think here if we don't take more intensive action now. Either we stay status quo so to speak or we make a stick that is bigger than we've been using. If, for instance, we can prove, and I think we can easily, that a large segment of the physicians in the State of Maryland really would sign something like this, then I think as the law now reads or at least as the regulations under which the law is operating now reads, the State of Maryland would be refused its funds, the matching funds, from the federal government under the present program. I don't think this might be a stick to help us with the legislation.

* * *

DR. SIMONS: Mr. President, I kind of lost the floor back there. I basically agree with what Dr. Speed had to say. I think we should point out that without question, the majority of this type of patient is being cared for by the minority of physicians, and that a majority vote by our membership wouldn't necessarily reflect how the people who are taking care of the medically indigent feels, but I agree with most of what he has said.

I strongly believe that the State of Maryland should assume its responsibility to pay the physicians to care for the medically indigent, and while I'm in general agreement with the objectives of the Resolution 6A/68, I do not believe that we should take precipitous action at this time. We know that the Governor and the State is in a difficult financial position because of the fall-off in state revenue. We know that the Governor has named a special committee to evaluate this, and the entire medical assistance program in the state.

We know that specific and initial recommendations have been made by this special committee and that the Governor has not, at this point, indicated his intentions with respect to these recommendations. Appropriate Faculty committees are working on this problem with the State Health Department and other interested and concerned governmental bodies. I believe that we should defer action on this resolution until our Semiannual meeting at which time the picture will be much clearer and further that this resolution be considered by the Reference Committee at its open hearings along with other resolutions up for consideration at the Semiannual session so that individual members and other interested parties can speak on it. Mr. President, I so move.

* * *

DR. FISHER: To indicate that what Dr. Simons has said makes sense, I have a memorandum which reached me today. The report of a phone conversation with one of the Assistant General Counsels of the Social Security Administration, and it pointed out, and this memorandum is obviously not matured (sic), but I quote a certain part of it because I think it has bearing. It says the question of merely non-submission of bills as being evidence of non-participation is difficult to answer. It may well be that if physicians do provide services for these patients, they are considered as participating whether or not they render bills. This point has never been raised, and would probably require court interpretation. So that it becomes more and more clear that some detailed consideration of such items as this is in order. I speak in favor of the motion.

* * *

DR. QUEEN: . . . I would like to ask one thing that worries me tremendously. I happen to practice in a hospital that is in somewhat of a poverty neighborhood.

A lot of the doctors who practice in that neighborhood where they publish lists of physicians who received this money from Medicaid, at least a high percentage of it, these men in my opinion have done a gigantic job. Also as we were told the day before yesterday by Dr. Peeples, that the reason this list was published, and I have read the entire list, and I'm sure our committees have checked into it and found that there was certainly no wrong being done, I look also when I see that as quoted down here about adequate consultations, about some of this being given, it was the Legislature that I find at fault and certainly not the doctors. What worries me more than anything is that I don't know this answer at all. If Dr. Speed does, I wish he would answer, but if we have a poll of the members, and let's say two-thirds of the members sign a pledge—like the group who have very nicely dedicated their lives almost to taking care of them. This is the group that I am very, very much afraid of because as I read this and I'm no lawyer at all, but it states somewhat that approximately two-thirds of the practitioners in the state. Are we going to be cut off from these extra funds so that at least this group will be again denied less treatment or will be denied treatment that they are now receiving. Maybe you could answer it or someone could answer it. This is what worries me more than anything.

* * *

DR. FISHER: Again, I can't answer if from my own knowledge, but another part of this same memorandum to which I referred discussed it at some length; the question of the guideline portion that's quoted, and indicates that this percentage is not a hard and fast figure, but he speculated, and I emphasized that this was speculations by the Assistant General Counsel of the Medical Services Program for the Social Security Administration that if less than the determined number of physicians were participating, federal funds could be withdrawn from that group which was not participating but that other services such as hospitals, nursing home, etc., could continue to receive federal support with the exception of those people who are being treated under medicaid by virtue of being on welfare payments because for those patients the law states all five services, hospital, nursing homes, laboratory, drug and physician care must be provided. It would seem, therefore, that the authority, if this legal opinion is correct, could be so split as to continue funding the people in the above welfare level, but still covered under Medicaid as medically indigent, but they would have to withdraw services from those in welfare.

Should this happen, there is lengthy negotiation between the state and the federal agency, and the federal policy would be reappraised to see if it is correct. Then it would be at the discretion of the administrator of the program to determine whether or not federal funds should be withheld from the entire or some part of the program. If funds are so withheld, there would be a hearing and the Secretary of HEW would then use his prerogative of making the decision as to what funds, if any, are to be withheld. If there were an adverse decision from him, the state would then have recourse to the federal court for a final determination of this. This is the concept that has been presented as to how the problem would be approached by HEW in response to action by the state.

If it's any clearer to you than it is to me, you may understand it.

* * *

DR. SPEED: I'd like to speak just briefly against this motion. Again, I am concerned about some of the things that have been voiced here this afternoon, and that is, that we do keep putting this business off every six months, and looking around the room I see a good many faces that have been here before, and who are, I think, aware of this problem, and I think those on the committees who are working for you and trying to resolve this problem ought to have some definite expression from the House of Delegates now as to how strongly do you feel about this, by either rejecting this motion or a similar motion or by acting on it.

I'm not sure that by going back to a Reference Committee you're going to gain anything more than you can gain by discussing it in open House right now.

* * *

DR. WALDEN: I agree that some action in this particular area is needed, but the resolution as I read it is a very bad one. The first resolved is in conflict with the third resolved. I don't see how the House of Delegates of the Faculty can pledge all of the physicians of the State to the action that is asked for in this resolution.

Again, the Professional (Medical) Services committee I think has mentioned that this resolution or this particular action would not be in the best interests of some of the physicians who are members of the Faculty and who care for the patients that fall in this category. I think that the motion made by Dr. Simons—or the motion that this be referred to a Reference Committee is a proper action. While, again, as I say, I think some action should be taken, but I don't think that this is the best way to do it.

* * *

Since the Annual Meeting many events have taken place that affect the operation of the Medical Assistance Program. The State has found itself in a most difficult financial situation and has elected to make some of the recipients under the program (approximately 130,000) pay 20% of the cost of the medical care provided them. It has been forced into the position of adopting most of the recommendations of the Ad Hoc Health Planning Committee, which include the deletion of some persons (approximately 22,000) from the rolls of the program; reduction of some fees and the placing of maximums on reimbursements to some of the providers of services (e.g., $12.00 per outpatient visit, instead of cost, to hospitals with organized Outpatient Departments). From the reading of the above, as well as a brief summary of activities that have taken place since our Annual Session, it can be seen that this problem has become more complex rather than clearer. The Maryland State Dental Association has adopted a resolution almost identical to Resolution 6A/68; and has asked representatives of the Faculty to meet with it to discuss these problems further. The Maryland Pharmaceutical Association has protested a reduction in its professional fee from $1.50 per Rx to $1.25, and has asked the U. S. Department of Health, Education and Welfare to intercede with the State Government on its behalf.

The Reference Committee is as perplexed as to what should be done as any of the members of the Faculty or any person involved in any way with the program. There is no doubt that the imposition of a co-pay feature of the program will mean that physicians, pharmacists, hospitals and others will, once again, be called on to subsidize the medical assistance program; will have abuse heaped on them, for "profiteering" from the program by

politicians who, in the first place neglected to provide sufficient funds to operate in a realistic manner. We feel that this follows the normal pattern wherein those persons who adequately provide care in a sympathetic manner are berated because of their philanthropy. No credit has been given to the health services groups for the dozens of years of service provided at no cost at all, or at less than the actual costs of delivering such services. The Reference Committee also noted that, once again, in accord with the Resolution, these decisions were taken unilaterally, without consultation with the providers of the service. As has been the reason in the past, the governmental agency involved in these decisions claims that lack of time prevents such consultation.

Your Reference Committee is of the opinion that a simpler substitute resolution may accomplish what must be done in this area; and, therefore, recommends adoption of the following SUBSTITUTE RESOLUTION 6A/68:

Whereas, The Medical and Chirurgical Faculty of the State of Maryland believes that it was not the intent of the United States Congress to continue to have health care provided our needy citizens on a hit or miss basis; and

Whereas, Taxpayers and voters are being deceived by the disparity between the promises of elected officials and their willingness to allocate funds for the fulfillment of these promises; now, therefore, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland believes that minimum standards provided for in Federal legislation and regulations; as well as a requirement that annual improvements be made in programs offered by the various states are all realistic; and be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland *initiate discussions,* along with other providers of health services to Maryland medically needy persons, with appropriate State Government officials for the purpose of presenting a unified approach to an effective and satisfactory solution to this overall problem; with the understanding that if sufficient funds are not available to provide the necessary services that government officials should be urged to provide for an appropriate tax increase to pay for such services; and that failing agreement in this area satisfactory to all of the medical service groups, each will ask its governing bodies to reconsider participation in Maryland's Medical Assistance program; and be it

Resolved, That this matter be placed on the agenda for the next House of Delegates meeting, and that this be considered a continuing item on the agenda of future House of Delegates sessions until it is resolved in one way or another, and be it

Resolved, That copies of this resolution be sent to all officials concerned with the operation of this program.

If the above substitute resolution is adopted, the comments and suggestions offered to the Reference Committee, both verbally and in writing, will be provided to Faculty representatives for their information in their discussions with State authorities.

Resolution 1S/68

Submitted on:	July 5, 1968
Introduced by:	Marion Friedman, MD, and 31 other members of the Baltimore City Medical Society
Subject:	Workmen's Compensation Cases being charged on the basis of "Usual, Customary and Reasonable Fees"; and suggesting a course of action in this regard

Whereas, The United States Government through its various health programs such as Medicare (Title 18), the Federal Employees Health Insurance Program, and U. S. Armed Forces Dependents Medical Care Program, as well as many others, is based on the concept of payment to the physician of his Usual and Customary Fee; and

Whereas, The United Steel Workers of America has negotiated contracts with their employers that provide for provision of health insurance making payment to physicians on the basis of their Usual and Customary Fees; and

Whereas, The House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland on September 9, 1966, adopted a resolution in which the "resolved" portion reads as follows:

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland go on record as urging its members to submit bills for payment of "usual, customary and reasonable fees" for professional services rendered Workmen's Compensation Cases, as well as other Governmental agencies; and

Whereas, The present provisions of the Workmen's Compensation Law, Article 101, Section 37(c) reads as follows:

"All fees and other charges for such treatment and services shall be subject to regulation by the Commission, and shall be *limited to such charges as prevail in the same community for similar treatment of injured persons of a like standard of living.";* and **(emphasis ours)**

Whereas, The Workmen's Compensation Commission has authorized hospitals providing services to persons covered under the Workmen's Compensation Laws of this State to bill at their "posted charges," without having to request a hearing and without obtaining permission for any such increases in charges; and

Whereas, Under present regulations of the Workmen's Compensation Commission the individual physician is forced to request arbitration of fees by the Commission when Insurance Carriers elect not to pay the physician's Usual and Customary fees but abide rigidly to the Fee *Guide* published by the Workmen's Compensation Commission; and

Whereas, Within the Medical and Chirurgical Faculty's organization are reliable mechanisms through which questionable fees charged by physicians may be adjudicated; and

Whereas, At least ten other States already work under the concept of Usual, Customary and Reasonable fees for physicians' services in their handling of Workmen's Compensation cases; and

Whereas, There is no reason why Workmen's Compensation Recipients should be treated differently from other patients of physicians; and

Whereas, This disparity in treatment by Insurance Carriers and the Commission could lead to substandard medical treatment of Workmen's Compensation Cases; now, therefore, be it

Resolved, That Physicians in Maryland be urged to advise all insurance carriers that they intend to charge their Usual, Customary and Regular fees for Workmen's Compensation cases seen by them; and be it further

Resolved, That Insurance Carriers who continue to arbitrarily reduce fees paid to physicians for such Workmen's Compensation cases be taken to court so that a test case can be made to determine if they are in violation of the law as it is presently written; and be it further

Resolved, That physicians who elect not to see such Workmen's Compensation Cases because of this arbitrary attitude on the part of the groups involved so notify the Insurance Carriers, requesting them to seek the services of other physicians for care of such patients.

This is somewhat similar to a resolution adopted by the House of Delegates in September, 1966, the Resolved of which says:

"Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland go on record as urging its members to submit bills for payment of 'usual, customary and reasonable fees' for professional services rendered Workmen's Compensation Cases, as well as all other Governmental agencies."

At the time this resolution was adopted, the House was advised that the Statute dealing with Workmen's compensation cases, reads as follows:

"All fees and other charges for such treatment and services shall be subject to regulation by the Commission, and shall be limited to such charges as prevail in the same community for similar treatment of injured persons of a like standard of living."

The Statute still reads the same.

We have been advised that discussions are still continuing with the Workmen's Compensation Commission in an attempt to resolve this. It is the hope of the Faculty Committee charged with this responsibility that a joint meeting will be held within the next few weeks with the full Commission to discuss this matter in more detail.

The Reference Committee does not feel that anything is to be gained at this time in adoption of Resolution 1S/68, but recommends that *Action on Resolution 1S/68 be postponed until the Annual Session of the House of Delegates in 1969.*

Resolution 2S/68

Submitted on: July 11, 1968
Introduced by: 41 Members of the Baltimore City Medical Society
Subject: Requesting endorsement of the continuation of Diploma Schools of Nursing by the Faculty; "importuning" the AMA and the AHA to implore the National League of Nursing and ANA to encourage and support continuation of such schools; pending evaluation by qualified persons

Whereas, There is an increasing shortage of Registered Nurses in the State of Maryland, and

Whereas, This shortage has occasioned the understaffing of many, and the closing of some, nursing units in the State leading to less and poorer patient care, and

Whereas, The trend for the development of extended and custodial care units will increase the demands for Registered Nurses, and

Whereas, Graduates of the numerous diploma schools in the State offer the largest practical available source to fulfill this need, and

Whereas, It appears that the training given to and the service rendered by the graduates of these diploma schools is superior to that of associate degree schools, and

Whereas, The horizons of nursing care are ever broadening, it is unrealistic to believe that the graduates of two year associate degree schools can be as skilled and knowledgeable in nursing technique as those of the diploma schools, and

Whereas, Many of the graduates of the degree schools are not interested in bedside nursing, and none are hospital oriented so as to assume patient care responsibilities without a period of instruction, now, therefore, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland endorse the continuation of diploma schools in the State and Country, importune the American Medical Association and the American Hospital Association to implore the National League of Nursing and the American Nursing Association to encourage and support with funds the continuation of the diploma schools until the whole matter may be further evaluated by a group of physicians, nurses, educators, and administrators, and until there could be an orderly transition so that no interruption of flow of graduate nurses will ensue.

For some time now there has been a trend toward the disbandment of so-called "diploma" schools of nursing. Taking the place of these schools are the so-called "degree" schools. Nursing has paralleled medicine in its attempts to upgrade the quality of the graduate. This has been necessitated by the increasing quantity of medical material that must be assimilated to become a well-rounded nurse or a well-rounded physician.

Your Reference Committee is of the opinion that the adoption of the following Substitute Resolution 2S/68 will accomplish the same objectives and will emphasize the studies that are currently under way in this area by the American Medical Association and other interested professional groups.

Whereas, In the face of an increasing demand for Registered Nurses in the State of Maryland, created in part by the development of Extended and Custodial Care Units, which has occasioned the understaffing of many, and the closing of some units; and

Whereas, Graduates of the numerous diploma schools in the State have offered the largest practical source to fulfill this need for Registered Nurses, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland endorses the continuation of diploma schools in this State and Country; and urges the American Medical Association, the American Hospital Association, the National League for Nursing and the American Nurses' Association to encourage and support the continuation of the diploma schools until the whole matter has been evaluated by the National Commission For the Study of Nursing Education.

Your Reference Committee would like to express appreciation to those persons who took the time to appear before it and express their views on the various items under discussion. Without their assistance and the amount of knowledge at their fingertips, it would not have been possible to reach the decisions enumerated in this report.

Respectfully submitted,

Herbert H. Leighton, MD, Oakland, *Chairman*
DeWitt E. DeLawter, MD, Bethesda
William H. Mosberg, MD, Baltimore
Emmanuel A. Schimunek, MD, Baltimore
Raymond M. Yow, MD, Salisbury

MINUTES OF THE BUSINESS SESSIONS

First Meeting, Semiannual Session, House of Delegates (262nd Meeting)

Medical and Chirurgical Faculty of the State of Maryland

Thursday, September 5, 1968 Ocean City, Maryland

The 262nd meeting, first of the Semiannual Session, of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland was called to order at 8:15 PM, Thursday, September 5, 1968, at the Diplomat Motel, Ocean City, Maryland, the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance: An asterisk indicates an alternate delegate.

Doctors: Robert T. Adkins, Wicomico County; Manning W. Alden, Council; Robert G. Angle, Montgomery County; Timothy D. Baker, Baltimore City; John G. Ball, Council; Edward M. Barczak, Baltimore City; *Wilbur N. Baumann, Dorchester County; Richard D. Bauer, Council; *Francis J. Borges, Baltimore City; Henry A. Briele, Council; M. McKendree Boyer, Past President; Douglas G. Carroll, Baltimore City; Robert G. Chambers, Baltimore City; *Katharine A. Chapman, Montgomery County; Henry V. Chase, Council; John T. Chissell, Council; *Shirley R. Clinton, Baltimore City; Archie R. Cohen, Council; Ernest I. Cornbrooks, Baltimore City; Kenneth Cruze, Montgomery County; Worth B. Daniels, Baltimore City; Melvin B. Davis, Baltimore County; John B. De Hoff, Baltimore City; DeWitt E. DeLawter, Montgomery County; John M. Dennis, Council; J. Sheldon Eastland, Past President; George O. Eaton, Council; William Carl Ebeling, Council; Wolcott L. Etienne, Council; *Robert W. Farr, Kent County; James McC. Finney, Harford County; Vincent J. Fiocco, Carroll County; Russell S. Fisher, Council; *Wilmer K. Gallager, Jr.; Baltimore County; Harold H. Gist, Washington County; Gina M. Glick, Allegany County; *Robert B. Goldstein, Baltimore City; Edward G. Grau, Baltimore County; Paul F. Guerin, Council; J. Roy Guyther, St. Mary's County; William B. Hagan, Council; John C. Harvey, Council; William G. Helfrich, Baltimore City; Thomas F. Herbert, Howard County; J. Parran Jarboe, Council; Page C. Jett, Calvert County; Frederick M. Johnson, Charles County; Ferd E. Kadan, Baltimore City; James R. Karns, Baltimore City; Arthur T. Keefe, Jr., Council; Lauriston L. Keown, Baltimore City; Robert C. Kimberly, Council; Edward L. J. Krieg, Baltimore County; Mr. Donn Larson, AMA Field Representative; Henry P. Laughlin, Council; C. Rodney Layton, Queen Anne's County; Herbert H. Leighton, Garrett County; Norman Levin, Baltimore City; Leon R. Levitsky, Prince George's County; *Eugene J. Linberg, Baltimore City; Elmer G. Linhardt, State Bd. of Med. Exam.; William J. McClafferty, Baltimore City; *Charles B. Marek, Baltimore City; Karl F. Mech, Council; *Benjamin S. Miller, Prince George's County; B. Martin Middleton, Council; John E. Miller, Baltimore City; Donald W. Mintzer, Baltimore City; Clayton Norton, Anne Arundel County; Sidney Novenstein, Washington County; Charles F. O'Donnell, Past President; J. Allen Offen, Montgomery County; Hilary T. O'Herlihy, Anne Arundel County; William A. Pillsbury, Council; Carolyn S. Pincock, Montgomery County; J. Morris Reese, Past President; Guy M. Reeser, Jr., Talbot County; Henry G. Reeves, Wicomico County; Thomas R. Reid, Frederick County; Philip L. Repetto, Jr., Prince George's County; *James A. Roberts, Montgomery County; Raymond C. V. Robinson, Baltimore City; Donald J. Roop, Council; Salvador Rossello, Baltimore City; John F. Schaefer, Council; Emmanuel Schimunek, Baltimore City; Arthur G. Siwinski, President; R. Kennedy Skipton, Prince George's County; Gordon M. Smith, Montgomery County; Aaron C. Sollod, Baltimore City; William G. Speed, III, Council; E. L. Suarez-Murias, Baltimore City; Thomas E. VanMetre, Jr., Baltimore City; Emerson Walden, Baltimore City; J. Arthur Weinberg, Council; Charles H. Williams, Baltimore County; *Thomas M. Wilson, Montgomery County; Donald O. Wood, Baltimore County; *Alan C. Woods, Baltimore City; Charles E. Wright, Frederick County; John D. Young, Jr., Baltimore City; Raymond M. Yow, Council.

Present also were staff personnel.

INVOCATION

Donald W. Mintzer, MD, delivered the invocation.

ANNOUNCEMENTS

The President made certain announcements with regard to the conduct of business at the session.

INTRODUCTION OF NEW MEMBERS

The President introduced the following new members of the House of Delegates:

John G. Ball, MD, Bethesda (Council)
Henry C. Briele, MD, Salisbury, First Vice President (Council)
John T. Chissell, MD, Baltimore (Council)
John M. Dennis, MD, Baltimore (Council)
George O. Eaton, MD, Baltimore, Third Vice President (Council)
Wolcott L. Etienne, MD, College Park (Council, also Second Vice President)
J. Parran Jarboe, MD, La Plata (Council)
Seruch T. Kimble, MD, Silver Spring (Council)
Elmer G. Linhardt, MD, Annapolis, State Board of Medical Examiners
J. Allen Offen, MD, Bowie, Delegate, Montgomery County.

MINUTES

The minutes of the House of Delegates of the April 17, 1968 and April 19, 1968 sessions having been distributed to the members and having been approved by the Executive Committee, were presented to the House for information.

EMERITUS MEMBERSHIP

On motion of the Council Chairman, the following members who had received the recommendation of their respective societies and the Council, were elected to Emeritus Membership in the Faculty:

Washington County:
Harry D. Bowman, MD, Hagerstown
Ralph F. Young, MD, Williamsport

Montgomery County:
Charles H. Wolohon, MD, Silver Spring

Baltimore City:
John A. Askin, MD, Baltimore
Arthur J. Owen, MD, Baltimore

Baltimore County:
J. Everett Sanner, MD, Baltimore

BYLAWS COMMITTEE REPORT

Charles F. O'Donnell, MD, Chairman of the Bylaws Committee, on its behalf, moved the adoption of the following Bylaw amendment which, after debate, was adopted by more than the required two-thirds vote:

Amend Article I, by adding new Section 6 to read as follows:

"Section 6. The term 'doctor of medicine' as used in these Bylaws is interpreted to include the degree 'doctor of osteopathy' when such individual holds a valid license to practice medicine and surgery in Maryland."

The Chairman then reported on two matters referred to it by the House of Delegates, offering no proposed amendments in this regard.

The Chairman then asked for permission from the House of Delegates to have the Faculty's Delegates to the American Medical Association House of Delegates introduce a resolution into that House for the purpose of amending the AMA Bylaws to provide for admission of Doctors of Osteopathy to active AMA membership. This was granted.

REPORT OF THE FACULTY DELEGATES TO THE AMA HOUSE OF DELEGATES

Russell S. Fisher, MD, on behalf of the Faculty's Delegates to the AMA House of Delegates, offered the information report of the AMA House session in San Francisco, June, 1968.

AD HOC COMMITTEE TO REVISE THE MEDICAL PRACTICE ACT

John M. Dennis, MD, Chairman of the Ad Hoc Committee to Revise the Medical Practice Act, on behalf of the Ad Hoc Committee moved that the House of Delegates adopt in principle the proposed Revised Medical Practice Act and urge the Maryland Legislature to substitute it for the present Medical Practice Act.

The proposed Revised Medical Practice Act, after debate and amendment, was adopted as amended as follows:

PROPOSED, REVISED MEDICAL PRACTICE ACT

Section 1. **Definitions.**

As used in this Act the following terms have the meanings indicated unless the context in which the terms are used indicates a contrary meaning:

(a) "Board" or "Board of Medical Examiners" means the Maryland State Board of Medical Examiners.

(b) "Commission" means the Commission on Medical Discipline of Maryland.

(c) "Faculty" means the Medical and Chirurgical Faculty of the State of Maryland.

(d) "Physician" means any person, including Doctors of Osteopathy, licensed to practice medicine in the State of Maryland in compliance with the provisions of this Act.

(e) "Practice of Medicine" means the exercise of the art and science of medical diagnosis, whether for compensation or gratuitously, healing or surgery and shall include:

(1) Operating on, professing to heal, prescribing for or otherwise diagnosing or treating any physical or mental or emotional ailment or supposed ailment of another,

(2) Undertaking by appliance, test, operation or treatment to diagnose, prevent, cure, heal, prescribe for or treat any bodily or mental or emotional ailment or supposed ailment of another.

(3) Undertaking to treat, heal, cure of remove any physical, mental or emotional ailment or supposed ailment of another by mental or emotional or other process exercised or invoked on the part of either the physician, the patient or both.

(f) but shall not include:

(1) Administering anesthesia by a dentist provided that the dentist does not engage in such administration as a medical specialty,

(2) Practicing anesthesiology or giving anesthesia for medical purposes by a dental surgeon who has regularly administered anesthesia in hospitals in this State for a period of not less than fifteen years prior to June 1, 1962,

(3) Selling proprietary or patent medicines,

(4) Practicing as an optician,

(5) Massage by hand, or other manipulation by hand but by no other means,

(6) Practicing the tenets of Christian Science by practitioners registered in the Christian Science Journal of the Christian Science Publishing Society,

(7) Practicing the following professions as registered, certified, or licensed and defined by law: chiropractic, dentistry, dental hygienics, midwifery, nursing, psychology, podiatry, practical nursing, optometry, pharmacy, physical therapy, osteopathy, except osteopaths required to be licensed under this Act.

Section 2. **The Board of Medical Examiners—Establishment.**

The Board of Medical Examiners of the State of Maryland is hereby established.

(a) It shall consist of eight Members who shall be elected by the Medical and Chirurgical Faculty of the State of Maryland at its annual meeting.

(b) The Members shall be physicians practicing medicine in the State of Maryland.

(c) A majority of the Members of the Board shall constitute a quorum.

(d) The Members shall serve a four-year term and may succeed themselves.

(e) Two Members shall be elected by the Faculty each year. The terms shall commence on the first day in June next following the election of the Members.

(f) In the event of a vacancy, the Board shall select a new Member to serve until his successor, elected at the next annual meeting of the Faculty, takes office.

(g) The Governor may remove any Member of the Board for cause.

Section 3. **The Board of Medical Examiners—Powers and duties.**

The Board shall have the following powers and duties:

(a) It shall establish examinations to be taken by applicants for license to practice medicine in the State of Maryland.

(b) It shall establish such other qualifications of applicants for license to practice medicine as the Board deems advisable.

(c) It shall license qualified applicants to practice medicine in the State of Maryland.

(d) It shall make an annual report to the Faculty.

(e) It shall issue certificates of professional standing to physicians for use in other jurisdictions.

(f) It shall authorize payment of expenses and compensation to its Members and others.

(g) It shall hold one or more meetings each year for

examination of applicants. Notice of such meetings shall be made public.

(h) It shall maintain a list of all applicants for license in the State.

(i) It shall maintain a Registry of Physicians.

(j) It shall report to the Commission acts by a physician sufficient to revoke or suspend the license of, or reprimand, such physician.

(k) It shall have a secretary-treasurer and such other officers and employees as it deems necessary.

(l) It shall promulgate rules and regulations necessary to effect this Act.

Section 4. **Practice without license.**

1) No person shall practice medicine in this State unless he is licensed by the Board and is registered in accordance with the provisions of this Act except as hereinafter provided.

2) The following persons may practice without a license, but subject to rules, regulations and orders of the Board and Commission:

(a) A resident, intern or student, or equivalents at any hospital or office of physician who is engaged in hospital, dispensary or similar duties.

(b) A physician licensed by and residing in another jurisdiction when engaged in consultation with a physician in this State.

(c) A commissioned surgeon of any of the Armed Forces of the United States, the United States Public Health Service Hospitals and the Veterans Administration while engaged in the performance of duties incident to his commission.

(d) A physician who resides in a neighboring jurisdiction who is authorized under the laws of such jurisdiction to practice medicine therein and whose practice extends into this State, provided such physician shall not open an office or have a regularly appointed place to meet patients within this State and further provided that the same privileges are extended to physicians from this State by such neighboring jurisdiction.

Section 5. **Qualifications of applicants for license.**

The applicant for license must have the following qualifications:

(a) Be at least twenty-one years of age.

(b) Be of good moral character.

(c) Have the degree of Doctor of Medicine or Doctor of Osteopathy from a school in the United States or foreign country which has standards for graduation equal to those standards established by the Association of American Medical Colleges, the Council on Medical Education of the American Medical Association, or the American Osteopathic Association. Applicants having the degree of Doctor of Osteopathy must, in addition to the foregoing, have completed a one-year internship in an intern training program approved by the American Medical Association Council on Medical Education or such other agency recognized by the National Commission on Accrediting.

Section 6. **License without examination.**

1) The Board may license without examination the following:

(a) Applicants having the qualifications required by Section 5 and having certificates of proficiency and professional standing of the National Board of Medical Examiners or boards of medical examiners of other jurisdictions, the requirements of which are equal to those of this State, provided that such other jurisdictions grant the same privileges to licensed physicians of this State.

(b) Applicants licensed under the provisions of Sections 467-480, inclusive, of Article 43 of this Code and practicing and residing in the State of Maryland on June 1, 1967, and graduates on or after 1940 of schools of Osteopathy approved by the American Osteopathic Association, or graduates prior to 1940 of such approved schools of Osteopathy provided that said applicants have completed a refresher educational course approved by the Board and were practicing and residing in the State of Maryland on June 1, 1967.

(c) Nothing herein shall apply to Doctors of Osteopathy licensed to practice medicine in other jurisdictions.

2) Nothing contained herein shall alter or diminish the right of any osteopath licensed in this State on or before June 1, 1967, to practice Osteopathy.

Section 7. **License upon special examination.**

Applicants of conceded eminence and authority in the profession from other jurisdictions may be licensed by the Board upon special examinations provided such applicants have the qualifications required for examination in the State and have practiced medicine for ten years.

Section 8. **Temporary Permit to practice medicine.**

A Temporary Permit to practice medicine, without examination, may be issued by the Board to a qualified physician for the purpose of post-graduate teaching. Such permits may be issued for the period of one year only.

Section 9. **Examination of medical students.**

Medical students of those medical schools accredited by the Association of American Medical Colleges or the Council on Medical Education of the American Medical Association may apply for examination upon the following:

(a) Verified completion of the second year of study in such subjects as the Board deems proper.

(b) Verified completion of a complete course of medical study.

Section 10. **Registration.**

Physicians licensed to practice medicine and surgery in the State of Maryland shall register with the Board. The registration shall be a permanent record of the Board entitled "Registry of Physicians".

(a) The Registry shall be a public record and shall be evidence to the same extent as are Land

Records as provided in Article 35, Section 40 of this Code.

(b) The Board shall provide for re-registration not less than every third year.

Section 11. **Commission on Medical Discipline of Maryland.**

1) Commission. The Commission on Medical Discipline of Maryland, hereby established and hereafter referred to in this section as the Commission, shall consist of the following persons:

(a) The President of the Medical and Chirurgical Faculty of the State of Maryland.

(b) Two practicing physicians appointed by the Governor of the State of Maryland, selected from a list submitted by the Medical and Chirurgical Faculty of the State of Maryland, such list having been composed from a list of nominees submitted by Component Societies of the Medical and Chirurgical Faculty and two other licensed practicing physicians of the State of Maryland appointed by the Governor of the State of Maryland.

(c) Three members of the Board of Medical Examiners to be selected by the Board of Medical Examiners.

(d) The Chairman of the Council of the Medical and Chirurgical Faculty of the State of Maryland.

2) Members. Seven of the nine members of the Commission are a quorum for the transaction of all business.

The Commission may establish and maintain an office within this State and shall make, adopt and promulgate rules and regulations for its own government and for the proper supervision and control of the professional conduct of all persons under its jurisdiction, as provided herein and not inconsistent with the laws of this State or of the United States.

There shall always be nine members and no person shall serve in a dual capacity. If there are nominations which would lead to such an occurrence, the Governor may designate a practicing physician from a list submitted by the Medical and Chirurgical Faculty of the State of Maryland, such a list having been composed from a list of nominees submitted by Component Societies of the Medical and Chirurgical Faculty.

3) Terms of Office. The terms of office for each appointed shall be for three years or until his successor is duly elected or appointed and qualified. Terms of office shall be from the first of July each year, except when the initial appointments are made, and there shall be three persons for one year, three persons for two years, and three persons for three years.

4) Reports. The Commission shall make annual reports to the Governor, the Board of Medical Examiners, and the Medical and Chirurgical Faculty of the State of Maryland.

5) Removal of members. Any member of the Commission may be removed by the Governor for neglect of duty, misconduct, or malfeasance or misfeasance in office.

6) Compensation. Members of the Commission shall receive no salary but may be reimbursed for actual expenses incurred in connection with their official duties with the Commission.

7) Procedure. The Commission shall refer any cases coming to its attention to the the appropriate local county society or Committee of the Medical and Chirurgical Faculty of the State of Maryland, for investigation and report. The report shall be acted upon within 90 days unless there is a time extension granted by the Commission. The report shall contain such recommendations as the investigation reveals might be necessary for adequate disciplinary procedures. The recommendations will then be considered by the Commission, which will take whatever action it deems appropriate, as provided herein. All such investigations, reports and recommendations shall be considered confidential until such time as a final action is taken by the Commission.

The Medical and Chirurgical Faculty of the State of Maryland may initiate action by virtue of information coming to its attention from its own members or through any other source, such cases being handled in the same manner as though they had been referred to it by the Commission.

8) Powers. When the Commission has completed its investigation according to the process outlined herein, it shall have the power to reprimand a physician or place him on probation, revoke or suspend his license, or dismiss the charges against any licensed physician for any of the causes listed below as unprofessional conduct:

(a) Fraudulent or deceptive procuring or use of a license.

(b) Solicitation or advertising contrary to Section 13 of this Act.

(c) The performance of an abortion, contrary to Section 15 of this Act.

(d) Conviction of a crime involving moral turpitude.

(e) Abandonment of a patient.

(f) Addiction to narcotics, habitual drunkenness or rendering professional services to a patient if the physician is intoxicated or under the influence of drugs.

(g) Promotion by a physician of the sale of drugs, devices, appliances or goods provided for a patient in such a manner as to exploit the patient for financial gain of the physician.

(h) Immoral conduct of a physician in his practice as a physician.

(i) Willfully making and filing false reports or records, in his practice as a physician.

(j) Willful omission to file or record, or willfully impeding or obstructing a filing or recording, or inducing another person to omit to file or record medical reports required by law.

(k) Failure to furnish details of a patient's medical record to succeeding physicians or hospitals upon proper request.

(l) Solicitation of professional patronage by agents or persons, or profiting from the acts of those representing themselves to be agents of the licensed physician.

(m) Division of fees or agreeing to split or divide the fees received for professional services with any person for bringing to or referring a patient.

(n) Willful misrepresentation in treatments.

(o) Practicing medicine with an unlicensed physician except in an accredited preceptorship or residency training program; or aiding or abetting such unlicensed persons in the practice of medicine.

(p) Gross and willful and continued overcharging for professional services; including filing of false statements for collection of fees for which services are not rendered.

(q) Offering, undertaking or agreeing to cure or treat disease by a secret method, procedure, treatment or medicine.

(r) Professional or mental incompetency.

9) Subpoena. The Commission may issue subpoenas and administer oaths in connection with any investigation, hearing or proceeding under this section.

10) Hearing and attorney rights. Any physician who has a case referred to the Commission on medical discipline shall have the right to appear in person before the Commission at a hearing duly convened to consider said case, at which time he may be represented by counsel; all proceedings of the Commission shall be subject to the provisions of the Administrative Procedures Act in Article 41 of this Code.

11) Certificate of revocation or suspension—Reprimand. If a majority of the members of the Commission find the accused guilty of unprofessional conduct as specified in the charges, the Commission shall prepare written finding of fact and may thereafter prepare and file in the office of the Board of Medical Examiners a certificate or order of revocation, suspension, or reprimand, in which case notice thereof shall be served upon the accused forthwith.

12) Dismissal of charges—Exoneration. If the license holder is found not guilty, the Commission shall forthwith order a dismissal of the charges and the exoneration of the accused, and no further action may be taken by the Commission on the charges involved. After such finding of not guilty, the Commission shall expunge all records.

13) Revocation or suspension of license—Stay pending review. The filing by the Commission in the office of the Board of Medical Examiners of a certificate or order of revocation or suspension, after due notice, hearing and findings in accordance with the procedure specified in this section, certifying that any holder of a license has been found guilty of unprofessional conduct by the Commission shall constitute a revocation or suspension of the license to practice medicine and surgery in this State in accordance with the terms and conditions imposed by the Commission and embodied in the certificate or order of revocation or suspension. If the licensee seeks judicial review of the Commission's decision pursuant to the provisions of this section, such revocation or the period of such suspension shall be stayed and shall not be effective or commence to run until final judgment has been entered in any proceeding instituted under the provisions of this section and the licensee's judicial remedies exhausted hereunder.

14) Contents of certificate—Recording. The certificate or order of revocation or suspension shall contain a brief and concise statement of the ground or grounds upon which the certificate or order is based and the specific terms and conditions of such revocation or suspension, and shall be retained as a permanent record by the Board of Medical Examiners as well as by the Commission.

15) Issuance of license after revocation or suspension. The Board of Medical Examiners shall not issue any license or any renewal thereof to any person whose license has been revoked or suspended by the Commission except in conformity with the terms and conditions of the certificate or the order of revocation or suspension, or in conformity with any order or reinstatement issued by the Commission or in accordance with the final judgment in any proceeding for review.

16) Appeal from decision by Commission. Any person whose license has been revoked or suspended by the Commission, or any person placed on probation under this section, may have a judicial review of the Commission's decision. He may enter any appeal to the Supreme Bench of Baltimore City or in the Circuit Court in the County in which the charges originated or in which the physician maintains his principal office and serve notice of said appeal on the Commission within 30 days after the filing of the certificate or of the revocation, suspension, probation or reprimand.

Section 12. **Advertising.**

No physician shall advertise except as provided by regulations of the Board.

Anatomical Gift Act

Section 13. **Legislative intent.**

Because of the rapid medical progress in the field of tissue and organ preservation, the transplantation of tissue, and tissue culture, and because it is in the public interest to aid the development of this field of medicine, it is the policy and purpose of the General Assembly of Maryland in enacting this Act to encourage and aid the development of reconstructive medicine and surgery and the development of medical research by facilitating pre-mortem and post-mortem authorizations for donations of tissue and organs. It is the purpose of this Act to regulate only the gift of a body or parts of a body to be made after the death of a donor.

Section 13A. **Definitions.**

1) Person. Means individual, corporation, government or governmental agency or subdivision, estate, trust, partnership or association, or any other legal entity.

2) Body or part of body. Includes organs, tissues, bones, blood and other body fluids, and "part" includes "parts".

3) Licensed hospital. Includes any hospital licensed by the State Board of Health and Mental Hygiene under the laws of this State, and any hospital operated by the United States government, although not required to be licensed under the laws of the State of Maryland.

4) Licensed physician or surgeon. Means any physician or surgeon licensed to practice under the laws of this State.

Section 13B. **Persons who may execute an anatomical gift.**

1) Any individual who is over the age of twenty-one (21) years of age and who is competent to execute a will may give all or any part of his body for any one or more of the purposes specified in this Act, the gift to take effect after death.

2) Unless he has knowledge that contrary directions have been given by the decedent, the following persons, in the order of priority stated, may give all or any part of a decedent's body for any one or more of the purposes specified in this Act:

(a) the spouse, if one survives;

(b) an adult son or daughter;

(c) either parent;

(d) an adult brother or sister;

(e) the guardian of the person of the decedent at the time of his death;

(f) any other person or agency authorized or under obligation to dispose of the body.

If there is no surviving spouse and an adult son or daughter is not immediately available at the time of death of a decendent, the gift may be made by either parent. If a parent of decedent is not immediately available, the gift may be made by any adult brother or sister of decedent. But, if there is known to be a controversy within the class of persons first entitled to make the gift, the gift shall not be accepted. The persons authorized by this subsection to make the gift may execute the document of gift either after death, or during a terminal illness. The decedent may be a minor or a stillborn infant.

3) If the gift is made by a person designated in Section 13B. 2) of this Act, it shall be by written or telegraphic consent.

Section 13C. **Persons who may become donees, and purposes for which anotomical gifts may be made.**

The following persons are eligible to receive gifts of human bodies or parts thereof for the purposes stated:

1) Any licensed hospital, surgeon or physician; for medical education, research, advancement of medical science, therapy, or transplantation to individuals.

2) Any accredited medical school, college, or university engaged in medical education or research; for therapy, educational research, or medical science purposes.

3) Any person operating a bank or storage facility for blood, arteries, eyes, pituitaries, or other human parts; for use in medical education, research, therapy, or transplantation to individuals.

4) Any specified donee; for therapy or transplantation needed by him.

Section 13D. **Manner of executing anatomical gifts.**

1) A gift of all or part of the body for purposes of this Act may be made by will, in which case the gift becomes effective immediately upon death of the testator without waiting for probate. If the will is not probated, or if it is declared invalid for testamentary purposes, the gift, to the extent that it has been acted upon in good faith, is nevertheless valid and effective.

2) A gift of all or part of the body for purposes of this Act may also be made by document other than a will. The document must be signed by the donor in the presence of two witnesses, who, in turn, shall sign the document in the donor's presence. If the donor cannot sign in person, the document may be signed for him, at his discretion and in his presence, and in the presence of two witnesses, who, in turn, shall sign the document in the donor's presence. Delivery of the document or gift during the donor's lifetime is not neccessary to make the gift valid. The document may consist of a properly executed card carried on the donor's person or in his effects. The document and/or card shall conform substantially to the following form:

"Certificate of Authorization for Post-Mortem Study and Examination or Removal of Tissues or Organs

I, the undersigned, this ---------- day of ----------, 19------, desiring that my ----------
be made available after my demise for:

A. Any licensed hospital, surgeon or physician; for medical education, research, advancement of medical science, therapy or transplantation to individuals;

B. Any accredited medical school, college or university engaged in medical education or research; for therapy, educational, research or medical science purposes;

C. Any person operating a bank or storage facility for blood, arteries, eyes, pituitaries, or other human parts, for use in medical education, research, therapy or transplantation to individuals;

D. The donee specified below, for therapy or transplantation needed by him or her; do hereby donate my ---------- ---------- for said purpose to

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(Name of Person) (Address)

I hereby authorize a licensed physician or surgeon or the State Anatomy Board to remove and preserve for use my ---------- for said purpose.

Witnessed this --------- day of ----------, 19----

(Donor)

(Name and Address)

(Address)

(Name and Address)

(Telephone)

The gift becomes effective immediately after the death of the donor.

3) The gift may be made either to a named donee, or without the naming of a donee. If the latter, the gift may be accepted by and utilized at the discretion of the attending physician at or following death. If the gift is made to a named donee who is not readily available at the time and place of death, and if the gift is evidenced by a properly executed card or other document carried on the donor's person, or in his effects, the attending physician at or following death may, in reliance upon the card or other document, accept and utilize the gift in his discretion, as the agent of the donee. The agent possesses and may exercise all of the rights and is entitled to all of the immunities of the donee under this Act.

4) The donor may designate in his will or other document of gift the surgeon, physician, or technician to carry out the appropriate procedures. In the event of the non-availability of such designee, or in the absence of a designation, the donee or other person authorized to accept the gift may employ or authorize any licensed surgeon, licensed physician, or technician for the purpose.

5) A document of gift executed in another state and in accord with the laws of that state thereunto pertaining or executed in a territory or possession of the United States under the control and dominion of the federal government exclusively, and in accord with a federal law thereunto pertaining, shall be deemed valid as a document of gift within the State of Maryland, notwithstanding that the said document does not substantially conform to the requirements of Section 13D. 2) of this Act.

Section 13E. **Delivery to donee.**

If the gift is made to a named donee, the will or other document or an attested true copy thereof may be delivered to him, to expedite the appropriate procedure, immediately after death; but such delivery is not necessary for validity of the gift. Upon request of the named donee or his agent on or after the donor's death, the person in possession shall produce, for examination, the will or other document of gift.

Section 13F. **Revocation of gift.**

1) Any document of gift which has been delivered to the donee may be revoked by either—
   (a) the execution and delivery to the donee or his agent of a revocation in writing, signed by the donor, or
   (b) an oral statement of revocation witnessed by two persons, and communicated to the donee or his agent, or
   (c) a statement during a terminal illness addressed to the attending physician and communicated to the donee, or his agent, or
   (d) a card or other writing signed by the donor and carried on his person or in his effects, revoking the gift.

2) Any document of gift which has not been delivered to the donee may be revoked in the manner set out in subsection 1) of this section, or by destruction, cancellation, or mutilation of the document.

3) Any gift made by a will may be revoked in the manner set out in subsection 1) of this section, or in the manner provided for revocation or amendment of wills.

Section 13G. **Effect of gift on rights of donee.**

1) The donee may accept or reject the gift. When the gift is only a part of the body, promptly following the removal of the part named, custody of the remaining parts of the body shall be transferred to the next of kin, or other person or agency authorized or under obligation to dispose of the body. The time of death shall be determined by the physician in attendance upon the donor's terminal illness or certifying his death, and said physician shall not be a member of the team of physicians which transplants the part to another individual.

2) A person who, in good faith and acting in reliance upon and authorization made under the provisions of this Act and without notice of revocation thereof, takes possession of, performs surgical operations upon, or removes tissue, substances, or parts from the human body; or refuses such a gift; or any person who unknowingly fails to carry out the wishes of the donor according to the provisions of this Act, shall not be liable for damages in a civil action brought against him for such act.

3) The provisions of this Act are subject to the laws of this State prescribing powers and duties with respect to autopsies and are not in contravention thereof.

Section 13H. **Effect of gift during lifetime of donor.**

The provisions of this Act shall not apply to gifts of parts of the body when said gifts are made during the lifetime of the donor with the intention that the said part of the body be delivered to the donee during the lifetime of the donor.

Section 13I. **Severability.**

If any provision of this Act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the Act which can be given effect without the invalid provisions or applications, and to this end the provisions of this Act are declared to be severable. If any section, paragraph, clause or sentence of this Act shall, for any reason, be adjudged by any court of competent jurisdiction to be unconstitutional and invalid, such judgment shall not affect, impair, or invalidate the remainder thereof,

but shall be confined in its operation to the section, paragraph, clause, or sentence thereof so found to be unconstitutional and invalid.

Section 13J. **Prior authority or instrument.**

Nothing in this Act shall invalidate any authority or instrument executed prior to July 1, 1968.

Section 13K. **Short title.**

This Act may be cited as the Anatomical Gift Act.

Section 14. **Consent of minors.**

1) The consent of the provision of medical or surgical care or services by a hospital, public clinic, or the performance of medical or surgical care or services by a physician, licensed to practice medicine, when executed by a minor who is, or professes to be married, or by a female minor who is or professes to be pregnant, or by a minor who is or professes to be afflicted with a venereal disease, shall be valid and binding as if the said minor had achieved his or her majority as the case may be; that is, a minor who is, or professes to be married, or a female minor who is, or professes to be pregnant, or a minor who is, or professes to be afflicted with a venereal disease, shall be deemed to have, and shall have the same legal capacity to act, and the same legal obligations with regard to the giving of such consent to such hospital or clinical care or services or medical or surgical care or services to be provided by a physician licensed to practice medicine, as a person of full legal age and capacity, the infancy of said minor and any contrary provisions of law notwithstanding, and such consent shall not be subject to later disaffirmance by reason of such minority; and the consent of no other person or persons (including, but not limited to a spouse, parent, custodian, or guardian) shall be necessary in order to authorize such hospital or clinical care or services or medical or surgical care or services to be provided by a physician licensed to practice medicine to such a minor or minor's child.

2) Upon the advice and direction of a treating physician or if more than one, any one of them, member of the medical staff of a hospital, public clinic, or physician licensed to practice medicine may, but shall not be obligated to, inform the spouse, parent, custodian or guardian of any such minor in the circumstances as enumerated in sub-section (a) hereof, as to the treatment given or needed, and such information may be given to, or withheld from the spouse, parent, custodian or guardian without the consent of the minor patient and even over the express refusal of the minor patient providing such information; the providing or withholding of such information to rest in the sole discretion of a member of the medical staff of the hospital, public clinic or the physician licensed to practice medicine, as the case may be. In the event that the said minor is found not to be pregnant or not afflicted with a venereal disease, then no information with respect to any appointment, examination, test or other medical procedure shall be given to the spouse, parent, custodian or guardian of said minor.

3) The provisions of this Section shall also apply to minors who profess to be in need of hospital or clinical care or services or medical or surgical care or services to be provided by a physician licensed to practice medicine, whether because of suspected pregnancy or venereal disease, regardless of whether such professed suspicions of pregnancy or venereal disease are, or are not subsequently substantiated on a medical basis.

4) Any consent given pursuant to the provisions of this Section by a minor shall not be deemed to be valid if, following a delivery or other termination of a pregnancy, it is determined that surgery not directly connected with the pregnancy is required or shall be requested.

Section 15. **Abortion.**

(A) No person shall terminate or attempt to terminate or assist in the termination of a human pregnancy otherwise than by birth, except that a physician licensed by the State of Maryland may terminate a human pregnancy or aid or assist or attempt a termination of a human pregnancy if said termination takes place in a hospital accredited by the Joint Commission for Accreditation of Hospitals and licensed by the State Board of Health and Mental Hygiene and if one or more of the following conditions exist:

(1) Continuation of the pregnancy is likely to result in the death of the mother;

(2) There is a substantial risk that continuation of the pregnancy would gravely impair the physical or mental health of the mother;

(3) There is substantial risk of the birth of the child with grave and permanent physical deformity or mental retardation;

(4) The pregnancy resulted from a rape committed as a result of force or bodily harm or threat of force or bodily harm and the State's Attorney of Baltimore City or the County in which the rape occurred has informed the hospital abortion review authority in writing over his signature that there is probable cause to believe that the alleged rape did occur.

(B) In no event shall any physician terminate or attempt to terminate or assist in the termination or attempt at termination of a human pregnancy otherwise than by birth unless all of the following conditions exist:

(1) Not more than twenty-six weeks of gestation have passed (except in the case of a termination pursuant to subsection (A) (1) or where the fetus is dead) ; and

(2) Authorization therefor has been granted in writing by a Hospital Abortion Review Authority appointed by the Hospital.

(C) The Hospital Abortion Review Authority shall keep written records of all requests for authorization and its action thereon. An annual report of the therapeutic abortions performed in Maryland

shall be made by the Director of the Hospital and its governing board. Such reports shall include the number of requests, authorizations and performances, the grounds upon which such authorizations were granted, and the procedures employed to cause the abortions and such reports shall be forwarded to the Joint Commission on Accreditation of Hospitals and the State Board of Health and Mental Hygiene for the purpose of insuring that adequate and proper procedures are being followed in accredited hospitals. Such information which is not subject to the physician-patient privilege, may be made available to the public. Said reports shall not include the names of the patients aborted.

Section 16. **Abortion—Refusal to participate.**

(A) No person shall be required to perform or participate in medical procedures which result in the termination of pregnancy; and the refusal of any person to perform or participate in these medical procedures shall not be a basis for civil liability to any person nor a basis for any disciplinary or any other recriminatory action against him.

(B) No hospital, hospital director or governing board shall be required to permit the termination of human pregnancies within its institution and the refusal to permit such procedures shall not be grounds for civil liability to any person nor a basis for any disciplinary or other recriminatory action against it by the state or any person.

(C) The refusal of any person to submit to an abortion or to give consent therefor shall not be grounds for loss of any privileges or immunities to which such person would otherwise be entitled nor shall submission to an abortion or the granting of consent therefor be a condition precedent to the receipt of any public benefits.

Section 17. **Abortion—Misdemeanor.**

(A) A person is guilty of a misdemeanor if he

(1) Sells or gives, or causes to be sold or given, any drug, medicine, preparation, instrument, or device for the purpose of causing, inducing, or obtaining a termination of human pregnancy other than by a licensed physician in a hospital accredited by the Joint Commission for Accreditation of Hospitals and licensed by the State Board of Health and Mental Hygiene; or

(2) Gives advice, counsel, or information for the purpose of causing, inducing, or obtaining a termination of human pregnancy other than by such physician in such a hospital; or

(3) Knowingly assists or causes by any means whatsoever the obtaining or performing of a termination of human pregnancy other than by such physician in such a hospital.

(B) Any person who violates any provision of this section, upon conviction, is subject to a fine of not more than five thousand dollars for each offense, or to imprisonment for not more than three years, or both such fine and imprisonment. The penalties in this section are in addition to and not in substitution for any other penalty or penalties applicable to particular classes of persons under other laws of this State.

(C) Nothing in Sections 15, 16 and 17 of this Act applies to, or affects the prosecution or penalty for any event or occurrence prior to July 1, 1968.

Section 18. **Aid at the scene of an accident.**

1) A physician who renders medical aid, care, or assistance not in a hospital, under emergency conditions at or near the scene of an accident or other occurrence for which he charges no fee or compensation shall not be liable for any civil damages as the result of any professional act or omission by him not amounting to gross negligence.

2) The members of volunteer ambulance and rescue squads shall not be liable for damages as provided in subsection (1) hereof, provided that such members have completed an advanced Red Cross or equivalent course in first aid, and be on duty as members of a volunteer ambulance and rescue squad which (a) is a bona fide and permanent organization and (b) is operated as a nonprofit group.

3) Registered nurses and licensed practical nurses shall have the same immunity from civil damages as are provided in subsection (1) hereof.

Section 19. **Cancer.**

1) No person other than a physician or dentist shall hold himself out as being able to treat, cure, or prescribe treatment for the disease of cancer.

2) No person shall sell, offer to sell, or give away, except on the prescription of a physician or dentist any drug, medicine, compound, nostrum, or device represented by the manufacturer or seller thereof to have curative powers in the treatment of the disease of cancer.

3) "Cancer" as used in this section means all malignant neoplasms regardless of the tissue of origin and includes but is not limited to malignant lymphoma and leukemia.

Section 20. **Confidential Records.**

1) All records, and other information procured by the Faculty, component societies, in-hospital staff committees and national medical societies or groups organized for research which contain the identity of any person are confidential records.

(a) Access to and use of such confidential records shall be regulated by Section 101 of Article 35 and Section 10 of Article 75C of this Code.

(b) Nothing in this section shall restrict publication of statistics and data which do not disclose the identity of any person.

2) All proceedings and transactions before the Faculty and records thereof pertaining to the investigation and report by the Faculty pursuant to Section 11 of this Act shall be confidential to the extent provided for by subsection (1) hereof.

Section 21. **Criminal Penalties.**

1) A person shall be guilty of a misdemeanor upon conviction of the following and shall be fined not less than one hundred dollars nor more than five thousand dollars, or imprisoned for not less than one year nor more than five years, or both:

   (a) The registration as a physician with the Board when such person is not a physician; or,

   (b) The presentation of any false information to the Board; or,

   (c) The practice of medicine contrary to Section 4 of this Act; or,

   (d) The treatment of cancer contrary to Section 19 of this Act.

2) A person shall be guilty of a misdemeanor upon conviction of the following and shall be fined not less than twenty-five dollars nor more than five hundred dollars:

   (a) The failure to register as required by Section 10; or,

   (b) Violating any of the provisions of Section 20.

Section 22. **Title.**

This act shall be known as the "Medical Practice Act."

Section 23. **Severability.**

Should any provision or application of this Act be held invalid, such invalidity shall not affect the other provisions or applications, and to this end the provisions of this Act are declared to be severable.

ADJOURNMENT

The House of Delegates adjourned at 9:45 PM until Friday, September 6, 1968, at 9:30 AM.

WILLIAM A. PILLSBURY, MD, SECRETARY

Second Meeting, Semiannual Session, House of Delegates (263rd Meeting)

Friday, September 6, 1968 Ocean City, Maryland

The 263rd meeting, second of the Semiannual Session, of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland was called to order at 9:40 AM; Friday, September 6, 1968, at the Diplomat Motel, Ocean City, Maryland, the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance: An asterisk indicates an alternate delegate.

Doctors: Robert T. Adkins, Wicomico County; Manning W. Alden, Council; Robert G. Angle, Montgomery County; Timothy D. Baker, Baltimore City; John G. Ball, Council; *A. N. Barr, Somerset County; Richard D. Bauer, Council; *Francis J. Borges, Baltimore City; Henry A. Briele, Council; McKendree Boyer, Past President; Douglas G. Carroll, Baltimore City; Robert G. Chambers, Baltimore City; *Katharine A. Chapman, Montgomery County; Henry V. Chase, Council; John T. Chissell, Council; *Shirley R. Clinton, Baltimore City; Archie R. Cohen, Council; Ernest I. Cornbrooks, Baltimore City; Kenneth Cruze, Montgomery County; Worth B. Daniels, Baltimore City; Melvin B. Davis, Baltimore County; John B. De Hoff, Baltimore City; DeWitt E. DeLawter, Montgomery County; John M. Dennis, Council; *Michael Dobridge, Montgomery County; J. Sheldon Eastland, Past President; George O. Eaton, Council; William Carl Ebeling, Council; Wolcott L. Etienne, Council; *Robert W. Farr, Kent County; James McC. Finney, Harford County; Vincent J. Fiocco, Carroll County; Russell S. Fisher, Council; Harold H. Gist, Washington County; Gina M. Glick, Allegany County; *Robert B. Goldstein, Baltimore City; Edward G. Grau, Baltimore County; Paul F. Guerin, Council; J. Roy Guyther, St. Mary's County; William B. Hagan, Council; John C. Harvey, Council; William G. Helfrich, Baltimore City; Thomas F. Herbert, Howard County; H. Logan Holtgrewe, Anne Arundel County; J. Parran Jarboe, Council; Frederick M. Johnson, Charles County; Ferd E. Kadan, Baltimore City; James R. Karns, Baltimore City; Arthur T. Keefe, Jr., Council; Lauriston L. Keown, Baltimore City; Robert C. Kimberly, Council; Seruch T. Kimble, Council; Edward L. J. Krieg, Baltimore County; Mr. Donn Larson, AMA Field Representative; Henry P. Laughlin, Council; C. Rodney Layton, Queen Anne's County; Herbert H. Leighton, Garrett County; Norman Levin, Baltimore City; Leon R. Levitsky, Prince George's County; *Eugene J. Linberg, Baltimore City; Elmer G. Linhardt, State Bd. of Med. Exam.; William J. McClafferty, Baltimore City; *Charles B. Marek, Baltimore City; Karl F. Mech, Council; *Benjamin S. Miller, Prince George's County; B. Martin Middleton, Council; John E. Miller, Baltimore City; Donald W. Mintzer, Baltimore City; Frederick E. Musser, Prince George's County; Clayton Norton, Anne Arundel County; Sidney Novenstein, Washington County; Charles F. O'Donnell, Past President; J. Allen Offen, Montgomery County; Hilary T. O'Herlihy, Anne Arundel County; William A. Pillsbury, Council; Carolyn S. Pincock, Montgomery County; J. Morris Reese, Past President; Guy M. Reeser, Jr., Talbot County; Henry G. Reeves, Wicomico County; Thomas R. Reid, Frederick County; Philip L. Repetto, Jr., Prince George's County; *James A. Roberts, Montgomery County; Raymond C. V. Robinson, Baltimore City; Donald J. Roop, Council; Salvador Rossello, Baltimore City; John F. Schaefer, Council; Emmanuel Schimunek, Baltimore City; Arthur G. Siwinski, President; R. Kennedy Skipton, Prince George's County; Gordon M. Smith, Montgomery County; Aaron C. Sollod, Baltimore City; William G. Speed, III, Council; Martin E. Strobel, Baltimore County; E. L. Suarez-Murias, Baltimore City; Francis J. Townsend, Worcester County; Aaron H. Traum, Montgomery County; Thomas E. VanMetre, Jr., Baltimore City; Emerson Walden, Baltimore City; *Hugh W. Ward, Calvert County; J. Arthur Weinberg,

Council; Charles H. Williams, Baltimore County; Donald O. Wood, Baltimore County; Alan C. Woods, Baltimore City; Charles E. Wright, Frederick County; John D. Young, Jr., Baltimore City; Raymond M. Yow, Council.

Present also were staff personnel.

ATTENDANCE OF PRESS AT SESSION

The President asked for a decision by the House of Delegates as to whether a request from the Press to be present at this session of the House should be honored. By a vote of 40 in the affirmative and 36 in the negative, it was agreed that press representatives should be allowed to attend this meeting of the House.

POLICY AND PLANNING COMMITTEE REPORT

Arthur T. Keefe, Jr., MD, Policy and Planning Committee chairman, on behalf of the Policy and Planning Committee moved adoption of the following proposed substitute motion for that suggested by the President of the Woman's Auxiliary at the Annual Session, Friday, April 19, 1968. After debate, it was voted to substitute the motion, which, also after debate, was adopted as follows:

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland favors 100% membership in the Woman's Auxiliary on a voluntary basis, but is of the opinion that a statewide assessment or dues increase creating involuntary membership would be unwise. Component Societies are encouraged to consider this matter individually, in order to arrive at the most equitable arrangement for each group.

SUBSTITUTE RESOLUTION 4A/68

Dr. Keefe then presented the proposal of the Policy and Planning Committee that Resolution 4A/68, referred to it by the House of Delegates, be rejected and a substitute policy be adopted by the House.

After debate and amendment the House voted to adopt Resolution 4A/68, which reads as follows:

Whereas, Incorporation of self-employed persons is an established practice in 35 states at this time; and

Whereas, The right of an individual physician to incorporate his medical practice in Maryland when deemed personally desirable, should not be denied; now, therefore, be it

Resolved, That the Medical and Chirurgical Faculty should support efforts of physicians or groups of physicians to incorporate provided that ownership and management is exercised solely and completely by licensed physicians; and be it further

Resolved, That the membership of the Medical and Chirurgical Faculty of the State of Maryland endorses and supports the principle of incorporation of self-employed persons at the option of the individual; and be it further

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of Maryland reverses its previous position taken in September, 1962, and now favorably endorses the incorporation of self-employed persons.

REFERENCE COMMITTEE REPORT

Herbert H. Leighton, MD, Reference Committee Chairman, then presented the report of the Reference Committee; and on its behalf moved the adoption of a substitute resolution for Resolution 6A/68, referred to it by the House of Delegates at The Annual Session.

SUBSTITUTE RESOLUTION 6A/68

AMENDMENT RULED OUT OF ORDER

An amendment to this substitute resolution was offered which was ruled out of order by the President because it was not germane to the resolution.

After debate, it was voted to lay this substitute and the original resolution on the table.

RESOLUTION 1S/68 POSTPONED UNTIL ANNUAL MEETING 1969

Dr. Leighton on behalf of the Reference Committee, then moved that action on Resolution 1S/68, be postponed until the Annual Session of the House of Delegates in 1969. The House voted postponement of action on Resolution 1S/68, which read as follows:

Whereas, The United States Government through its various health programs such as Medicare (Title 18), the Federal Employees Health Insurance Program, and U.S. Armed Forces Dependents Medical Care Program, as well as many others, is based on the concept of payment to the physician of his Usual and Customary Fee; and

Whereas, The United Steel Workers of America has negotiated contracts with their employers that provide for provision of health insurance making payment to physicians on the basis of their Usual and Customary Fees; and

Whereas, The House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland on September 9, 1966, adopted a resolution in which the "resolved" portion reads as follows:

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland go on record as urging its members to submit bills for payment of "usual, customary and reasonable fees" for professional services rendered Workmen's Compensation Cases, as well as other Governmental agencies; and

Whereas, The present provisions of the Workmen's Compensation Law, Article 101, Section 37(c) reads as follows:

"All fees and other charges for such treatment and services shall be subject to regulation by the Commission, and shall be *limited to such charges as prevail in the same community for similar treatment of injured persons of a like standard of living';* and (emphasis ours)

Whereas, The Workmen's Compensation Commission has authorized hospitals providing services to persons covered under the Workmen's Compensation Laws of this State to bill at their "posted charges," without having to request a hearing and without obtaining permission for any such increases in charges; and

Whereas, Under present regulations of the Workmen's Compensation Commission the individual physician is forced to request arbitration of fees by the Commission when Insurance Carriers elect not to pay the physician's Usual and Customary fees but abide rigidly to the Fee Guide published by the Workmen's Compensation Commission; and

Whereas, Within the Medical and Chirurgical Faculty's organization are reliable mechanisms through which questionable fees charged by physicians may be adjudicated; and

Whereas, At least ten other States already work under the concept of Usual, Customary and Reasonable fees for physicians' services in their handling of Workmen's Compensation cases; and

Whereas, There is no reason why Workmen's Compensation Recipients should be treated differently from other patients of physicians; and

Whereas, This disparity in treatment by Insurance Carriers and the Commission could lead to substandard medical treatment of Workmen's Compensation Cases; now, therefore, be it

Resolved, That Physicians in Maryland be urged to advise all insurance carriers that they intend to charge their Usual, Customary and Regular fees for Workmen's Compensation cases seen by them; and be it further

Resolved, That Insurance Carriers who continue to arbitrarily reduce fees paid to physicians for such Workmen's Compensation cases be taken to court so that a test case can be made to determine if they are in violation of the law as it is presently written; and be it further

Resolved, That physicians who elect not to see such Workmen's Compensation Cases because of this arbitrary attitude on the part of the groups involved so notify the Insurance Carriers, requesting them to seek the services of other physicians for care of such patients.

SUBSTITUTE RESOLUTION 2S/68 ADOPTED

Dr. Leighton, on behalf of the Reference Committee, moved that the following substitute Resolution 2S/68, be adopted. The House voted to adopt the substitute which read as follows:

Whereas, In the face of an increasing demand for Registered Nurses in the State of Maryland, created in part by the development of Extended and Custodial Care Units, which has occasioned the understaffing of many, and the closing of some units; and

Whereas, Graduates of the numerous diploma schools in the State have offered the largest practical source to fulfill this need for Registered Nurses, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland endorses the continuation of diploma schools in this State and Country; and urges the American Medical Association, the American Hospital Association, the National League for Nursing and the American Nurses' Association to encourage and support the continuation of the diploma schools until the whole matter has been evaluated by the National Commission For the Study of Nursing Education.

PRESENTATION OF VIET NAM PLAQUES

The President, on behalf of the Medical and Chirurgical Faculty presented a Viet Nam plaque for volunteer service in Viet Nam to Frederick M. Zerzavy, MD, who accepted this and commented briefly on his experiences in Viet Nam. Presentation of Viet Nam plaques for the following physicians was deferred until the annual meeting:

Thomas Powell, MD
Louis Padovano, MD
Glendon E. Royson, MD

J. G. F. SMITH, MD PLAQUE PRESENTATION

Presentation of a plaque honoring J. G. F. Smith, MD, of Brunswick, Md., was postponed because of Dr. Smith's inability to be on hand at the Semiannual session.

RESOLUTION HONORING WALTER N. KIRKMAN, ESQ. ADOPTED

Russell S. Fisher, MD, President-elect, offered the following resolution honoring Walter N. Kirkman, Esq., which was adopted unanimously by the House:

Whereas, the death of Mr. Walter N. Kirkman, occurring in July, 1968, leaves a void in State affairs, as well as those of the Medical and Chirurgical Faculty of the State of Maryland; and

Whereas, Walter was one of the only two lay persons ever honored by the Faculty by granting Honorary Membership to him in this organization; and

Whereas, in the few years that Walter Kirkman was actively employed by the Faculty he brought an understanding and helpfulness to Faculty problems that very few persons can; and

Whereas, the majority of his career was devoted to State Government which he served unselfishly and without desire for publicity or recognition beyond those for whom he labored; and

Whereas, The Medical and Chirurgical Faculty of the State of Maryland was honored when he agreed to assist it in its operations following his retirement from state service, therefore, be it

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland hereby goes on record as expressing its sorrow on the death of Walter N. Kirkman; and

Resolved, That this House also recognizes his services to the State of Maryland, in many capacities, both before and after his retirement as a state employee; and

Resolved, That a copy of this resolution be spread upon the minutes of this meeting of the House of Delegates, with a copy to be sent to his wife, Mrs. Florence Kirkman, expressing our gratitude and appreciation for the many hours of devotion he gave towards furthering the aims and ideals of the medical profession.

RESOLUTION HONORING WALTER D. WISE, MD ADOPTED

Dr. Fisher presented the following resolution honoring Walter D. Wise, MD, past-president of the Faculty, which was adopted unanimously by the House and reads as follows:

Whereas, Walter D. Wise, MD, one of Maryland's distinguished physicians, died suddenly on July 23, 1968; and

Whereas, during his life as a physician he held many high posts in the State and City, published more than 30 scientific articles in medical publications; and

Whereas, in all of these activities, such as Chairman of the Board of Governors at Mercy Hospital, member of the Advisory Board at Mount St. Agnes College, Medical Director of the Selective Service System, he served with distinction; and

Whereas, during this same period he served the Medical and Chirurgical Faculty in many capacities, including Council Chairman, President, Secretary, Curator, Chairman of the Library Centennial Exhibit Committee and in many other ways; and

Whereas, even though he held no official post, at his own request, he continued to have an abiding interest in Faculty activities; and

Whereas, his distinguished career was one which few people can attain; and

Whereas, his honors, awards, recognitions are too numerous to list and mention here; and

Whereas, his services to mankind both in and outside of the practice of medicine call for recognition beyond that due to past presidents, be it

Resolved, That this House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland hereby recognizes by formal vote the debt of gratitude it owes to Dr. Wise; and be it further

Resolved, That this House of Delegates spread this resolution upon the minutes of the House in order to express its appreciation of Dr. Wise's efforts on behalf of the public and profession over the years; and

Resolved, That this House of Delegates orders a copy of this resolution to be sent to the next of kin of Dr. Wise as a small recognition of its appreciation and gratitude.

SUBSTITUTE RESOLUTION 6A/68 REMOVED FROM THE TABLE AND RETABLED

A motion was offered to take Resolution 6A/68 and the proposed substitute for it from the table; following which it was moved and voted to retable Substitute Resolution 6A/68.

BALTIMORE CITY MEDICAL SOCIETY RESOLUTION OFFERED

R. C. Vail Robinson, MD, Delegate from Baltimore City, on behalf of the Baltimore City Delegation offered the following resolution for consideration of the House. By a vote of more than ⅔ of the members, it was agreed that this resolution be considered by the House.

Whereas, The State of Maryland has negated its medical assistance program as originally submitted to the United States Department of Health, Education and Welfare for approval under Title 19 of PL 89-97 by subsequently,

(1) eliminating at least 27,000 people from its roster

(2) instituting a co-pay policy for medical, pharmaceutical and dental programs for participating beneficiaries with annual income in excess of $1,200.00

(3) further instituting a co-pay policy for participating beneficiaries with annual income in excess of $1,200.00, necessitating the payment by the patient of the first $40.00 of any hospital admission expense; and creating a further hardship on the patient, by requiring $40.00 additional at the beginning of any subsequent concurrent 21-day period

(4) classifying individual participating beneficiaries in such a manner as to make those on public assistance easily recognizable as such, and thereby creating a bilevel society

(5) lowering the minimum yearly income level from $1,500.00 to $1,200.00

(6) making it increasingly difficult to establish eligibility for the program by excessive demands for proof, therefore, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland requests the United States Department of Health, Education and Welfare to investigate the legality of the program now operating in Maryland, to ascertain whether the State of Maryland is in compliance with the Guidelines as set forth by the United States Department of Health, Education and Welfare.

After debate, on a roll-call vote, the resolution was defeated by a vote of 47 in the affirmative and 49 in the negative. The roll-call vote is as follows:

AYES: Baker, Bauer, Carroll, Chambers, Chase, Chissell, Cornbrooks, Daniels, De Hoff, Eastland, Ebeling, Finney, Guerin, Guyther, Harvey, Helfrich, Kadan, Karns, Kimberly, Kimble, Krieg, Layton, McClafferty, Mech, Miller, O'Donnell, O'Herlihy, Rawley, Reid, Robinson (RCV), Roop, Rossello, Schimunek, Sollod, Strobel, Van Metre, Walden, Williams, Wood and Young. Alternate Delegates: Borges, Clinton, Farr, Goldstein, Marek, Dobridge and Valdes.

NAYS: Adkins, Alden, Angle, Ball, Briele, Boyer, Cohen, Cruze, Davis (Melvin), DeLawter, Dennis, Etienne, Fiocco, Fisher, Gist, Glick, Hagan, Herbert, Holtgrewe, Jarboe, Johnson, Keefe, Keown, Laughlin, Leighton, Levin, Levitsky, Linhardt, Middleton, B. Miller, Mintzer, Musser, Norton, Novenstein, Offen, Pillsbury, Pincock, Reeves, Repetto, Smith, Suarez-Murias, Townsend, Traum, Weinberg, Wright and Yow. Alternate Delegates: Chapman, Roberts and Woods.

ABSTAIN: Speed.

SUBSTITUTE RESOLUTION 6A/68 ADOPTED AS AMENDED

Resolution 6A/68 and its proposed substitute were taken from the table and, after debate and amendment adopted as follows:

Whereas, The Medical and Chirurgical Faculty of the State of Maryland believes that it was not the intent of the United States Congress to continue to have health care provided our needy citizens on a basis different from that of the non-needy citizen; and

Whereas, Taxpayers and voters are being deceived by the disparity between the promises of elected officials and their willingness to allocate funds for the fulfillment of these promises; and

Whereas, The program is now underfunded and we, the physicians of the Medical and Chirurgical Faculty, are concerned about unmet human needs; therefore, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland believes that minimum standards provided for in Federal legislation and regulations; as well as a requirement that annual improvements be made in programs offered by the various states are all realistic; and be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland continue discussions, along with other providers of health services to medically needy persons, with appropriate State Government officials for the purpose of presenting a unified approach to an effective and satisfactory solution to this overall problem; with the understanding that if sufficient funds are not available to provide the necessary services that government officials should be urged to provide for appropriate methods to pay for such services; and that failing agreement in this area satisfactory to all of the medical service groups, each will ask its governing bodies to reconsider participation in Maryland's Medical Assistance program; and be it

Resolved, That this matter be placed on the agenda for the next House of Delegates meeting, and that this be considered a continuing item on the agenda of future House of Delegates sessions until it is resolved in one way or another; and be it

Resolved, That copies of this resolution be sent to all officials concerned with the operation of this program.

ADJOURNMENT

A motion to adjourn, sine die, was then offered to the house and adopted, at 12:15 PM.

WILLIAM A. PILLSBURY, MD, SECRETARY

and Valium (diazepam)

The ability of Valium to help relieve skeletal muscle spasm—as well as psychic tension—demonstrates its clinical value and versatility.

The muscle-relaxant effect obtained with Valium, used adjunctively with other drugs or physiotherapy, favorably affects the entire cluster of spasm-related symptoms . . . helps accelerate return to normal activity.

When skeletal muscle spasm and psychic tension coexist, the calming effect of Valium is an added therapeutic benefit that contributes to the total management of the patient.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium® (diazepam)
2-mg, 5-mg, 10-mg tablets



Roche®
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



A littl

Just one 50 or 100 m
tablet in the morning
can work a long
diuretic day in edem
and hypertension.

HY-6060



Hygroton® can work a long day too

alorthalidone

at's because of its prolonged tion, which usually provides nooth diuretic activity roughout the day. And e-a-day dosage means few blets to take and few tablets pay for in the long run.

Hygroton, brand of chlorthalidone, may mean troublesome side effects for certain patients. And you can't prescribe it in cases of demonstrated hypersensitivity to the drug or in severe renal or hepatic diseases.

Before writing it for your patients, please check the Prescribing Information. It's summarized on the next page.

Hygroton

nlorthalidone in edema and hypertension

Geigy



in edema and hypertension

A little Hygroton® can work a long day

chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic diseases.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypotension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes urticaria, purpura, necrotizing angiitis acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.

(B)46-230-E

For full details, please see the complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

AMA Posture on Public Comment

The AMA Board of Trustees is cognizant of the great increase in attention being given in the press and broadcast media to medicine and health care. Our profession is now the focus of one of America's greatest interests. It will constantly be in the spotlight, ending the professional reticence and privacy in which medicine functioned most of the time in the past.

Even though this interest is a tribute to the importance of medicine and the public's desire for its benefits, it brings with it the problems facing any person or organization with a key public position: much of the coverage is critical or displays a lack of understanding.

The Board of Trustees has consulted with AMA staff and public relations counsel on this increasingly important situation. The conclusions that have resulted from this intensive and thoughtful consideration are submitted now:

1. When statements about medicine are misguided or unfair, corrective statements will be issued promptly when the facts are available and an orderly response is possible.

2. We must recognize that the prominence and complexity of medicine in the United States today result in many limitations. Medicine is a constant subject of news and comment, much of which cannot be subject to a later response. Often our replies cannot be carried by the broadcast medium or publication, or at best will be much less prominent than the original coverage. Quite often a responsible statement cannot be issued until the facts have been obtained, and these may be scattered about the country or involve a local situation or require a great deal of time.

3. The frequency and complexity of these matters have increasingly diverted the officers and staff of AMA to reacting to what others do and say. This decreases the ability to work on constructive, ongoing activities that are vital to our future.

4. Staff is developing in written form the best possible anticipatory statements regarding all foreseeable circumstances. By having such matters thought out and documented when a need arises, we will be able to reduce the instances of surprise, decrease the time required for response, and assure consistency in AMA statements on these matters.

5. We will concentrate on building a positive posture by getting understanding for medicine's functions and its positions on various considerations; and by educating the press, broadcasters and opinion leaders. This will help forestall much misguided criticism and build a favorable climate that will inoculate against susceptibility to unfair criticism.

6. All state and county medical societies are urged to follow these same procedures.

You will see many instances in which AMA responds to public comment, many in which we have acted, but our effectiveness will be in correcting the source and may not be visible immediately, and instances when judgment indicates a response should not be made. In each case the best judgment and skills will have been applied to the complexities of the situation.

Past House Action: C-67: 190, 200; C-66: 210-211; C-65: 195; A-64: 116-121; A-63: 87-89.

Adopted by AMA House of Delegates Aug. 14, 1968.

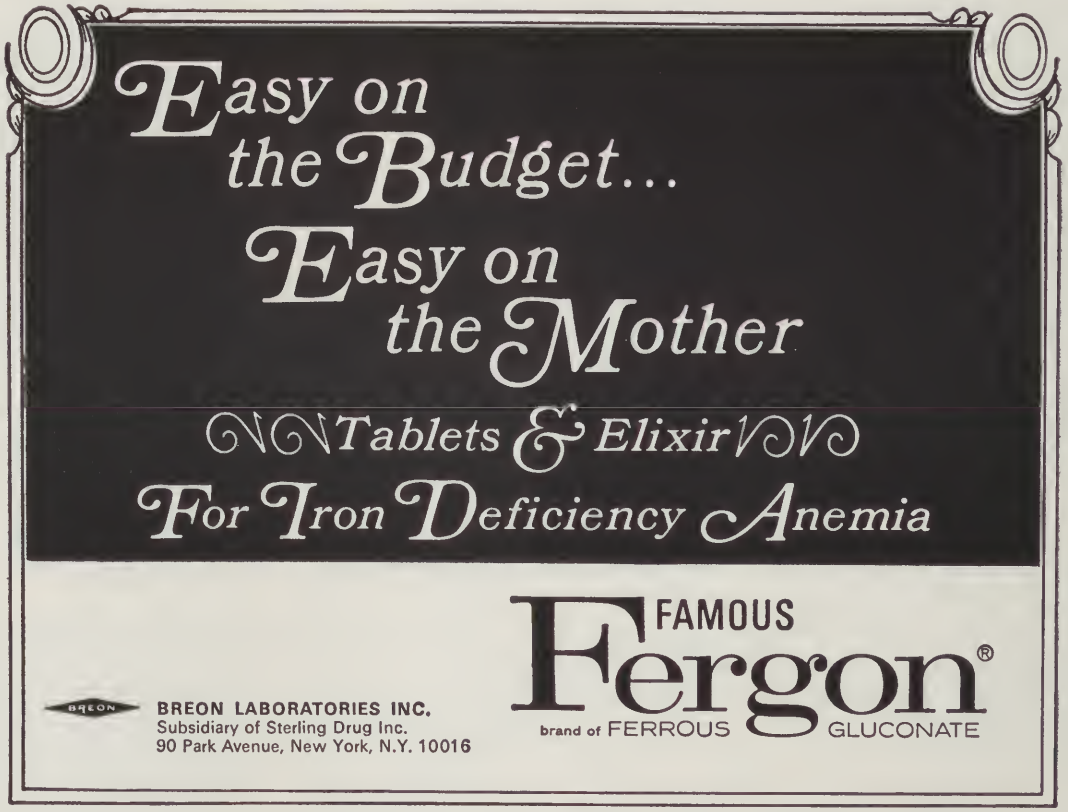
Presented by: Wesley W. Hall, MD, *Chairman*

ETHICS CORNER

While the Principles of Medical Ethics state that it is unethical for a physician to use prescription blanks imprinted with the name of a pharmacy, Maryland has a law stating that it is illegal for a pharmacy to provide blanks to physicians on which the name of the pharmacy is imprinted.

Carrying the Code of Ethics somewhat further, the Principles also state that a patient is entitled to a copy of his prescription for glasses, drugs or appliances and he has the privilege of having the prescription filled wherever he wishes.

Recently, instances have been brought to the attention of the Faculty office where physicians (or their office assistants) have indicated that copies of needed records, such as immunization procedures or other medical treatment, are not available to the patient until outstanding bills are paid. Here again, while a general ruling in this area cannot be provided, the ethics of such actions will depend upon the specific circumstances under which restrictions are laid down.





DOUGLAS G. CARROLL, MD, EDITOR

rehabilitation notes

Measurement of Performance in Rehabilitation*

SYMBOLISM, ABSTRACTION AND MEASUREMENT

"The writer is a trained biologist. Like most other trained biologists, he has a stake in knowing how far, and for what reasons, statistical theory can help us to enlarge our understanding of living matter. Since mathematical statisticians have not been hesitant to advance ambitious claims about the help it can give them, it is not presumptuous for a biologist to examine the credentials of such claims in the language of behaviour, the only language which all biologists share." Lancelot Hogben *Statistical Theory.*

* * * * *

For a full understanding of the process of measuring, it is necessary to consider the use of the various items of the ADL and MSCL scores and the meaning of diagnostic terms. Whenever an individual score is given in the ADL or MSCL or whenever a diagnosis is made, certain conditions (rules) have been fulfilled. The score number or the diagnosis stands for the observer's decision as to whether certain conditions have or have not been fulfilled. In the system described, either a number (in the case of the ADL and MSCL) or the diagnostic rubric (in the case of the diagnosis) is a symbol which stands for an event in progress which is called the designatum. The symbol is connected to the event by the observer. The relationship between the symbol and the designatum is called semantics. The basic question of semantics is "How well does this symbol describe this designatum?"

A second relationship is that between the interpreter and the symbol. This relationship is called pragmatics and answers the questions "How does the observer use the sign?", "What can cause an observer to misuse this sign?", "How well does the sign fulfill the purpose of the interpreter?".[1, 2]

In the development of a new method of measurement, symbols (in this case, the scores on the ADL and MSCL and the diagnoses) must be applied consistently to the same designatum. The symbol must, therefore, be defined specifically enough so that any observer will arrive at the same symbol to describe the same designatum. It is apparent that both the semantic and pragmatic purity of a method can be tested by comparing the results of two observers independently making the same measurement.

A second important consideration in the development of a new measuring device is the degree of abstraction inherent in the method. This consideration is particularly important if we expect to apply mathematical or statistical procedures to the derived symbols.

The very process of symbolizing into number, diagnostic rubrics or classes eliminates certain characteristics of the designatum. Further, we cannot represent a designatum completely by a symbol because signs and designata are *not* each other and do not structurally resemble each other. Thus,

* This is the seventh of a series of notes on "Rehabilitation of Chronic Impairments in Adults."

the diagnosis "fractured hip" has as many different designata as there are people who have fractured their hips.

Just as we have symbols which refer to objects or events, so symbols may also refer to other symbols. Thus, ordinary words (symbols) are the designata to which the symbols of semiotics refer. We may speak of these different modes of reference as being on different levels. The designatum (object) itself is on the first and lowest level. The observer is on the second level receiving direct sensory stimuli from the object in the form of light waves through the eyes, sound waves through ears, or other sensory intake. The integration of sensory intake and decision as to what symbol to apply is on a third level. The symbol or word is on a fourth level. The meta-symbol or symbol about a symbol is on a fifth level of abstraction.

Churchman and Ratoosh [3] have proposed that "the function of measurement is to develop a method for generating a class of information that will be useful in a wide variety of problems and situations." Measuring means the assignment of an entity to a position in a class or on a scale according to rule. Three types of scales are recognized in measuring.

A *nominal* scale merely means that items are "measured" by placing them in different classes. The items placed in the same class have certain similar characteristics which differentiate them from items placed in another class. The use of a nominal scale is generally designated as "categorizing" or "grouping". The classes may be numbered, but the number does not imply that the members of the class are greater or lesser, better or worse, smaller or larger than any other class. This is the way in which the diagnoses of various diseases are classified.

An *ordinal* scale also consists of placing entities into various classes, but now there is an implied relationship between the classes. Members of one class may be larger, hotter, colder than members of another class. The numbers referring to the classes imply a quantitative relationship between them, but the intervals between each class are not defined. That is, one class cannot be said to be twice that of another merely because its number is 2. Classes of diseases might be arranged into an ordinal scale if a relationship between them were defined and followed. We might, for example, arrange diagnostic classes on the basis of their prognosis for life into a series of increasingly serious prognoses. In the class with the best prognosis, we might place Coryza, Rubella and other generally non-fatal diseases. Pneumococcal pneumonia and pulmonary tuberculosis would constitute a second class, potentially fatal, but generally curable or arrestable. A third class would contain those diseases generally fatal, such as glioma multiforme and other malignant tumors. There is an implied relationship between the classes. Again, the diseases must be assigned to the classes by rule.

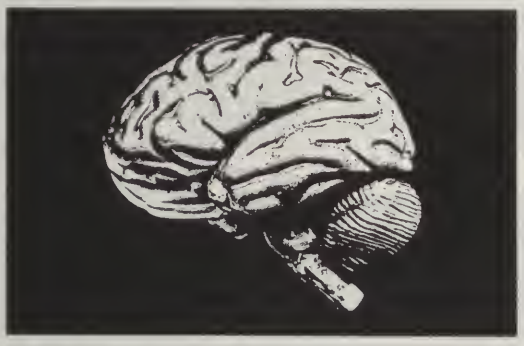
A third type of scale is the *interval* scale in which there are specific quantitative relationships between numbered classes. The measurement of length by a ruler is an example. Thus, boards may be placed into classes depending on their length. Examples of interval scales in medicine are temperature measurements, weight, height, age, biochemical and physiological measurements.

It is important to consider the three different types of scales of measurement in the application of statistical methods. It will be apparent that means and standard deviations calculated for ordinal scales are in error to the extent that the intervals on the scales are unequal in size.[4]

Having pointed out that the invention of an ordinal scale is a complex decision-making activity using highly complex abstraction, symbolization and assignment of numbers to events, one must hasten to point out that this procedure is the first step in the systematization of knowledge. This activity supplies numerical material for testing and predicting hypotheses. The hypothesis is made that objects or events (designata) exist to which symbols can be referred. The proof of this hypothesis ultimately rests upon the consensus of a society of observers. Before any statistical or mathematical manipulations can be applied to the classes or numbers collected in our diagnostic groups, the ADL score and the MSCL score, it must be demonstrated that there is observer agreement about ADL scores and MSCL scores. Once it has been shown that different observers independently and consistently reach similar symbolic formulations of groups and scores, it is then allowable to manipulate the groups and scores using mathematical and logical rules.

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2. Morris, C. W.: Foundation of the Theory of Signs. International Encyclopedia of Unified Science. Vol. 1 #2, University of Chicago Press, Chicago, Ill. 1939.
3. Churchman, C. W. and Ratoosh, P. (eds.): Measurement, Definitions and Theories. John Wiley and Sons, Inc., New York, 1959.
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JAMES E. CARSON, MD, COMMISSIONER
KURT GORWITZ, ScD, STATISTICS DIRECTOR

Maryland State department of mental hygiene

A Report to the Fifteen Southern States*

The Southern states have made substantial progress in recent years in providing improved hospital services for their mentally ill. The following table, based on statistics published by the Office of Biometrics of the National Institute of Mental Health, shows that despite this marked improvement the Southern states continue to lag appreciably behind the rest of the United States. The net difference in average daily per patient expenditure and in the number of employees for every 100 patients is now higher than it has been at any time previously.

Average Daily per Patient Expenditure	15 Southern States	Rest of United States	Net Difference	Percent Difference
1957	$2.62	$3.96	$1.34	—33.8
1962	3.91	5.91	2.00	—33.8
1966	5.72	8.41	2.69	—32.0
1967	6.43	9.68	3.25	—33.6
Number of Employees for Every 100 Patients				
1957	25.2	31.0	5.8	—18.7
1962	31.4	37.8	6.4	—16.9
1966	38.8	46.4	7.6	—16.4
1967	42.0	52.7	10.7	—20.3

Total hospital maintenance expenditures by the 15 states more than doubled in this ten-year period (from $121,000,000 in 1957 to $264,000,000 in 1967) and average daily per patient expenditures are now nearly two and one-half times the 1957 figure. However, since comparable changes have occurred in the other 35 states, the South's relative position has remained essentially unchanged. In fact, the South's daily average in 1967 of $6.43 was exceeded by 10% or more by nearly every one of the other 35 states. Related to this, the average size of the patient population declined 10.8% (from 126,585 to 112,919) in the Southern states during this ten-year span while the comparable figure for the rest of the country was 23.0% (from 422,745 to 325,668).

This disparity does not reflect a lesser interest and support for mental hospital programs. Rather, it is directly related to the relatively lower economic level of most Southern states. Latest figures released by the U. S. Department of Commerce indicate that per capita income in the South continues to be one-fourth lower than in the rest of the United States. This in turn has produced lower than average per capita expenditures for all state services.

The South has been characterized as an area in transition. Gradual economic and social development can be expected to produce in the mental health field a concomitant continuation of the progress experienced in recent years. However, it must be recognized that unless this is rapidly accelerated much of the South will perpetually continue to lag appreciably behind the rest of the United States.

* Alabama, Arkansas, Florida, Georgia, Kentucky, Louisana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia.

You be the judge, Doctor

Summation:
In addition to its primary indications for duodenal and gastric ulcer, Robinul Forte (glycopyrrolate) is indicated for other G-I conditions that may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

Contraindications: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

Precautions: Administer with caution in the presence of incipient glaucoma.

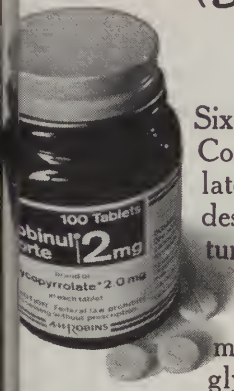
Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

Dosage: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day; on the a.m., early p.m., and at bedtime. See product literature for full prescribing information.

Supply: Robinul (glycopyrrolate 1 mg.): Robinul Forte (glycopyrrolate 2 mg.); Robinul-PH (glycopyrrolate 1 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming); Robinul-PH Forte (glycopyrrolate 2 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming), in bottles of 100 and 500 tablets. A. H. Robins Company, Richmond, Va. 23220.

A·H·ROBINS

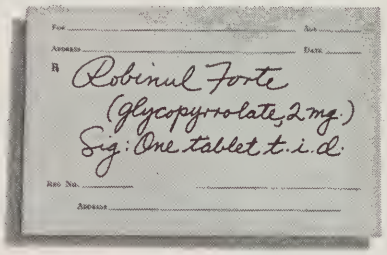
In peptic ulcer therapy, won't you give Robinul® Forte a Fair Trial?
(glycopyrrolate)



Six years ago the A. H. Robins Company introduced glycopyrrolate, a unique anticholinergic agent described in the prescribing literature as more closely approaching the ideal compound for controlling gastric hyperacidity and hypermotility of the G-I tract. Although glycopyrrolate (Robinul Forte) found good acceptance among numerous physicians, many others just didn't seem to want to give it a try, probably because the anticholinergic they were already using was giving acceptable results.

However, we believe you'll agree there's always room for a better anticholinergic. This is why we're asking you to give Robinul Forte a fair trial. Robinul Forte exerts a highly specific antisecretory action and marked inhibitory effect on intestinal tone. We're convinced you'll agree that this is indeed an outstanding drug when you observe its outstanding suppression of ulcer symptoms. Furthermore, it is unique in that it reduces intestinal tone, yet has little or no effect on peristalsis. In addition, the incidence of the more bothersome peripheral side effects is low.

No longer does the physician have to look for extreme dry mouth as the measure of his anticholinergic's effectiveness. The only way we can demonstrate to you firsthand the efficacy of glycopyrrolate (Robinul Forte) is for you to try it in your practice. That's why we're asking you to give it a Fair Trial. How can you give it a Fair Trial? You do it this way:



First: When you see your very next ulcer patient, write him a script as shown.

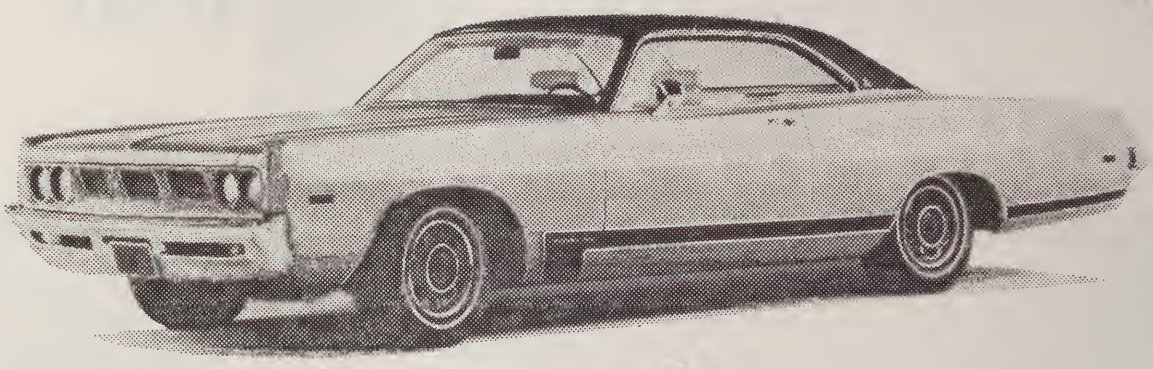
Next: Wait 10 days or until your patient comes in for his next appointment and get his "verdict" as to how he feels. Examine all the evidence and make your evaluation of his condition.



Finally: Render **your** verdict. If it's "significant improvement and marked relief of symptoms," then we believe you'll agree that Robinul Forte has proved its worth, and we rest our case. If not, consider our case for Robinul Forte closed. That's a Fair Trial, Doctor, and it's all we ask.

Robinul® Forte
(glycopyrrolate, 2 mg.)

The summation is an important part of every case. You'll find ours on the preceding page, Doctor.

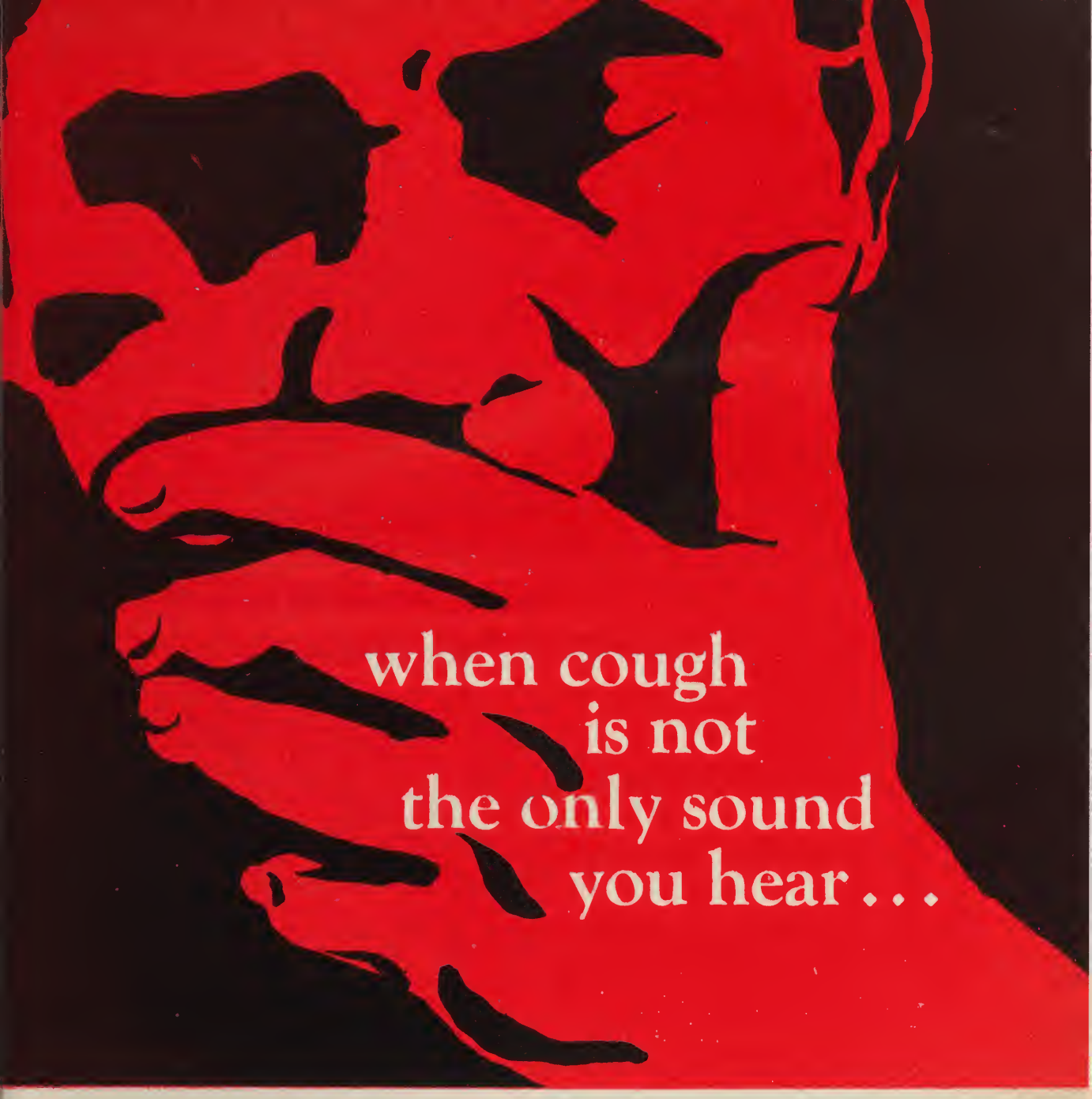


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. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

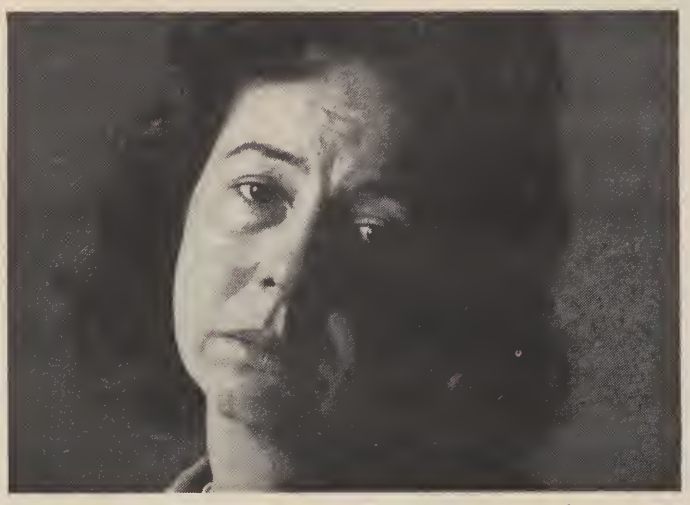
Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

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Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

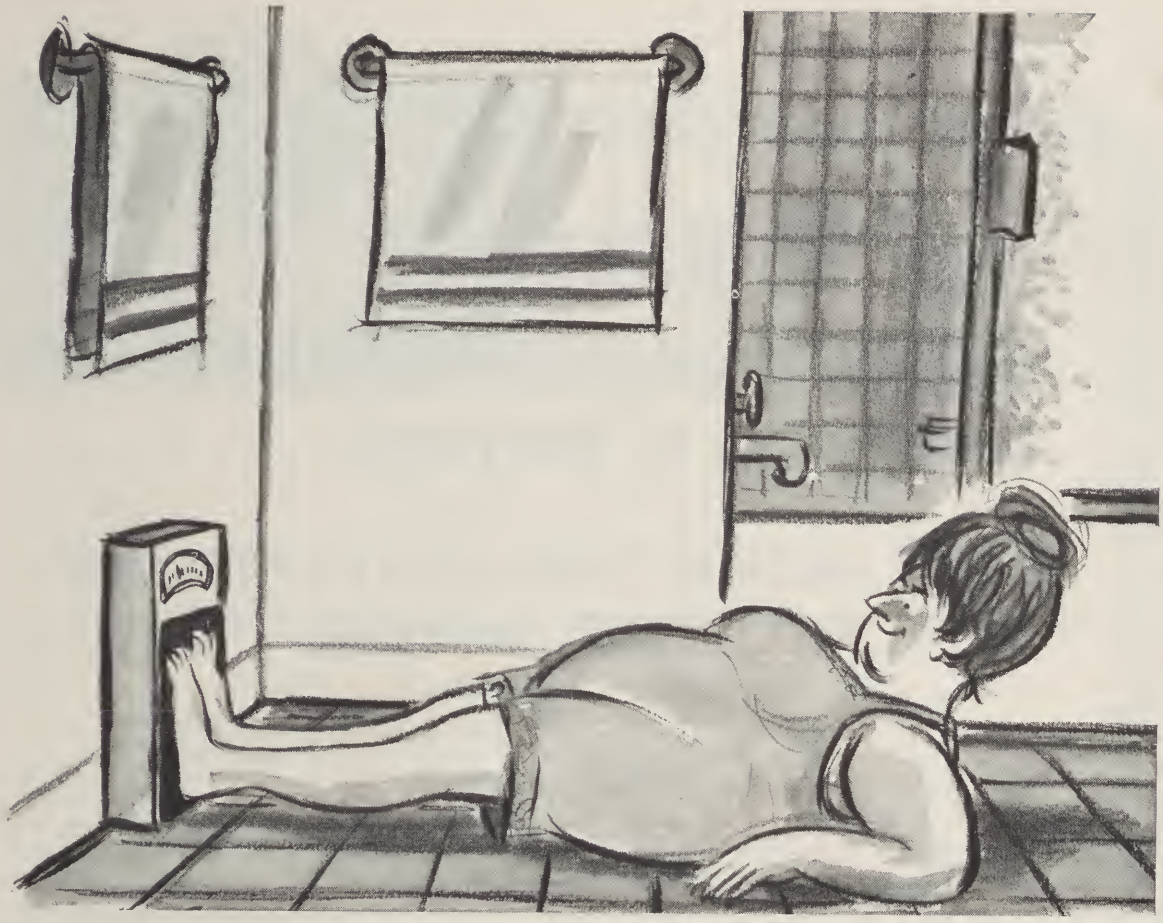
Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

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Contraindications: Hypertension, advanced arteriosclerosis, coronary artery disease, cardiac arrhythmias, peripheral vascular disease, states of undue restlessness, anxiety, excitement, agitated depression, hyperthyroidism, idiosyncrasy to amphetamine, concomitant administration of a monoamine oxidase inhibitor. **Precautions:** Use with caution in individuals with anorexia, insomnia, vasomotor instability, asthenia, psychopathic personality, a history of homicidal or suicidal tendencies, and individuals who are known to be hyperractive to sympathomimetic agents, or emotionally unstable individuals who are known to be susceptible to drug abuse. Certain monoamine oxidase inhibitors may potentiate the action of Obetrol. **Side Effects:** The most common side effects attended with the use of amphetamines include nervousness, excitability, euphoria, insomnia, dryness of mouth, nausea, vertigo, constipation, and headache.

Dosage and Administration: Initial adult dose is one-half to one 'Obetrol-10' tablet daily, preferably one-half to one hour before meals. This may be gradually increased to one 'Obetrol-10' or 'Obetrol-20' tablet one to three times daily as indicated. **Supplied:** Tablets scored, in bottles of 100. 500, and 1000.

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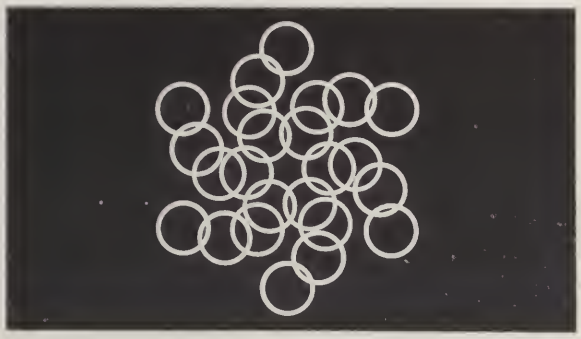
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From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

alcoholism section

Position Statement on Implementation of Comprehensive Intoxication and Alcoholism Control Act

The Department of Mental Hygiene weleomes Maryland's Comprehensive Intoxication and Aleoholism Control Act (effective July 1, 1968) as a pioneering measure to grant aleoholies their rights as siek people, and pledges energetie support to its implementation.

Mr. Justice Marshall in announcing the judgment of the Supreme Court in the case of *Leroy Powell v. State of Texas* stated, "The picture of the penniless drunk propelled aimlessly and endlessly through the law's 'revolving door' of arrest, ineareeration, rclease and re-arrest is not a pretty one. But before we eondemn the present practiee aeross the board, perhaps we ought to be able to point to some clear promise of a better world for these unfortunate people. Unfortunately, no sueh promise has yet been fortheoming."

The Control Act provides sueh a promise, and DMH personnel are aeutely awarc that 49 other states will be watehing Maryland's progress toward its realization. Already the North American Association of Aleoholism Programs and the National Council on Alcoholism have pointed to Maryland as affirming "the position which must eventually beeome thc law of the land."

Role of Division of Alcoholism Control

The Commissioner of Mental Hygiene, in compliance with the Act, has already established within the Department a Division of Alcoholism Control under the direction of "a licensed medical doctor." Division personnel include this part-time director, a coordinator of services to alcoholics, and an industrial alcoholism program advisor.

DMH has included in its FY '70 budget request the additional personnel necessary to carry the extensive duties and functions assigned to the Division in the Act. Since no additional funds were provided for implementation of the Act, the Division in fiscal '69 can take responsibility for only one portion of its assignment, and for that portion only to the extent that budgetary and personnel limitations permit. DMH has authorized its priorities as follows:

(1) Serve as a clearinghouse for alcoholism information;

(2) Develop and foster State-wide, regional and local alcoholism plans and programs;

(3) Provide technical assistance and consultation to political subdivisions on alcoholism programs;

(4) Stimulate more effective use of existing resources and services in alcoholism programs;

(5) Advise the Governor on effective coordination of public agencies in dealing with alcoholism problems;

(6) Assist public agencies and local subdivisions with applications for Federal grants for alcoholism programs;

(7) Advise the Governor on an alcoholism plan for inclusion in the comprehensive health plan;

(8) Encourage industrial alcoholism programs;

(9) Cooperate with State and local police on appropriate management of alcoholics;

(10) Promote the intent of the Legislature that alcoholics be admitted and treated in public and private hospitals without discrimination; and make recommendations to the Governor and the Legislature for legislation needed to accomplish this policy;

(11) Organize training programs on alcoholism for professional and non-professional personnel;

(12) Submit annual report and additional reports, on request, to DMH, the Legislature and the Governor;

(13) Develop State-wide plan to implement the objectives and policies of the Act, involving appropriate public and private agencies and institutions in the planning process and defining the role of each;

(14) Make every effort to utilize Federal funds, programs and facilities in implementing the Act;

(15) Prepare, publish and distribute educational alcoholism material;

(16) Gather alcoholism statistics;

(17) Enlist the assistance of public and voluntary health, education, welfare, and rehabilitation agencies in alcoholism programs;

(18) Maintain continuing evaluations of alcoholism programs, and conduct pilot and demonstration projects to improve them.

Without additional personnel, the Division will be unable to assume responsibility during fiscal '69 for the following functions:

(1) Prepare educational and treatment programs for those convicted of driving under the influence of alcohol;

(2) Cooperate with the Department of Correction on alcoholism programs in correctional institutions;

(3) Cooperate with educational departments and agencies and others on an alcoholism program for juveniles;

(4) Design, in coordination with other appropriate agencies, a comprehensive alcoholism educational program for the general public;

(5) Prepare and publish materials for a program of public education.

State Mental Hospital Role

DMH will continue to provide in the State mental hospitals alcoholic rehabilitation units "inpatient extended care facilities for intensive study, treatment, and rehabilitation of chronic alcoholics," and will make a determined effort within budgetary limitations to raise the standards of service as provided in the Act by:

(1) Providing equal treatment opportunities for male and female alcoholics;

(2) Developing a complete and permanent history on every patient;

(3) Providing each patient with a written plan for his future out-patient treatment;

(4) Readmitting patients who had previously left against medical advice;

(5) Providing specialized treatment for alcoholics with a primary diagnosis of mental illness;

(6) Recognizing alcoholic patients' right to send and receive mail without censorship;

(7) Admitting all patients with a primary diagnosis of alcoholism in the specialized Alcoholic Rehabilitation Units;

(8) Acting on the principle established in the Act that acute intoxication is a *medical* emergency and a local health responsibility, announcing at the earliest possible date that the State mental hospitals will admit and treat acutely intoxicated patients only when there is history of concomitant mental illness.

Responsibility of Other Resources

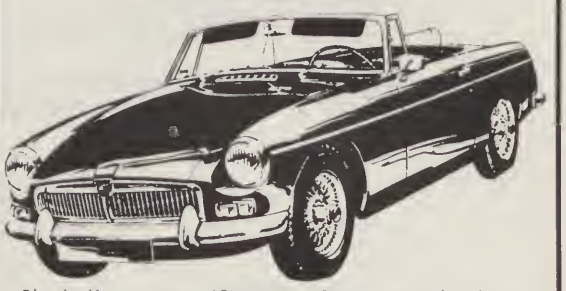
The Act, in both its letter and its spirit, recognizes the responsibility of two other major health

resources for the law's practical implementation: the responsibility of local health departments to provide leadership for, and to plan and to coordinate local efforts to treat alcoholics and control alcoholism; and the responsibility of general hospitals to accept alcoholics for medical treatment in their emergency rooms and on their medical services on equal terms with other kinds of patients, as the American Hospital Association has officially urged since 1957.

DMH has authorized Division personnel to give top priority attention during fiscal '69 to assisting in the development of local alcoholism programs, in cooperation with local health departments and general hospitals, and all other concerned agencies and agents.

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Obesity doesn't happen suddenly. This insidious process has its beginning—and the chances of reversing it are better—during the *first 10 to 15 pounds of weight gain.* When a new dietary pattern must be established, consider the adjunctive use of BAMADEX SEQUELS. Combining the proven *anorexigenic* action of d-amphetamine with the *tranquilizing* effect of meprobamate, BAMADEX SEQUELS controls appetite throughout the day, usually with a single capsule daily.

Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.
Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

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If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to NCME, 342 Madison Avenue New York, N.Y. 10017

In the complex picture of moderate to severe anxiety...



there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

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Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of the alka formulation are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.



Dosage in Painful Shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

(B) 46-070-8

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'm a real loser,
and so are
the kids."



The loss of marital compatibility results in nearly 500,000 U.S. divorces each year.

Depression characterized by untold guilt feelings, grief and loneliness may follow.

When you diagnose depression, Tofrānil may be indicated for relief.

As maintenance therapy during the active phase of depression, Tofrānil can often help prevent relapse.

The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated. In patients with cardiovascular disease, thyroid disorders, increased intraocular pressure; in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication or antihypertensive adrenergic neuron-blocking agents; and in those in their first trimester of pregnancy–the special precautions listed in the Prescribing Information should be carefully observed.

Toxic reactions severe enough to require discontinuation of Tofrānil are uncommon. However, for complete details, please refer to the complete Prescribing Information.

Turn page for brief summary of Prescribing Information.

in depression

Tofrānil® imipramine hydrochloride
Geigy

in depression





Tofrānil® Geigy

imipramine
hydrochloride

Tofrānil®, imipramine hydrochloride
Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be substituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, it should not be used during the first trimester of pregnancy. Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy. Because of its anticholinergic effect, caution should be observed in prescribing the drug for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when this compound was added to the regimen. Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 years of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (including hypomanic and manic episodes) which may require dosage reduction and/or addition of a tranquilizer or temporary discontinuation of the drug, epileptiform seizures, orthostatic hypotension and substantial blood pressure fall in hypertensive patients, purpura, transient jaundice, bone marrow depression including agranulocytosis, sensitization and skin rash including photosensitization, eosinophilia, and mild withdrawal symptoms on sudden discontinuation after prolonged treatment with high doses. Occasional hormonal effects (impotence, decreased libido, and estrogenic effects) may be observed. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those using anticholinergic agents (including antiparkinsonism drugs).
Outpatient Adult Dosage: Initially, 75 mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)R-46-850-C

For complete details, please refer to the full Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

TO-6757

WILLIAM J. PEEPLES, MD, MPH, COMMISSIONER

Maryland State department of health

Neurological Manifestations of Heart Disease

When neurological symptoms have an abrupt onset, one should always consider the possibility of heart disease as a primary or contributory cause of such symptoms. For example, it is not uncommon for a patient who has suffered an acute myocardial infarction to present clinically with hemiplegia or aphasia. Because these patients may have experienced no chest discomfort or are unable to give an adequate history due to mental confusion or aphasia, the possibility of an underlying or associated cardiac problem may be overlooked.

THOMAS R. PRICE, MD
Assistant Professor of Neurology
Department of Neurology
University of Maryland School of Medicine

In the case of acute myocardial infarction the cardiac output may be suddenly decreased by arrhythmias, congestive heart failure, or shock. This diminution in cardiac output may lead to a reduction in cerebral blood flow to a point at which ischemia or infarction of brain tissue may occur. The likelihood of such a problem is accentuated when significant atherosclerotic cerebral vascular disease is present. Another complication of myocardial infarction that could result in temporary or permanent neurological deficit is thromboembolism. Cerebral embolism may result from thrombus formation in the left heart. Thrombi may form over the infarcted endocardial surface or as a consequence of altered blood flow associated with an arrhythmia or congestive heart failure. Cerebral embolism most often involves a middle cerebral artery or one of its branches, and is most likely to occur between the second and fourth weeks following a myocardial infarction.

The clinical manifestations of acutely decreased cardiac output or cerebral embolism are commonly transient cerebral ischemic attacks or strokes. Strokes are focal neurological deficits of rapid onset which persist but are usually characterized by eventual partial or complete recovery. The most common type of stroke consists of hemiparesis and sensory loss, often accompanied by aphasia when the hemiparesis is on the right side. Other signs frequently noted are loss of vision, vertigo, diplopia, dysphagia and confusion. Transient cerebral ischemic attacks, on the other hand, are episodes of similar symptoms that usually last for from only seconds to hours, and are characterized by rapid, complete recovery. They often precede a complete stroke.

Because the sudden appearance of neurological symptoms warrants consideration of heart disease as the primary or associated cause of such symptoms, the patient's initial evaluation should include a thorough history and physical examination, an electrocardiogram, and possibly enzyme studies

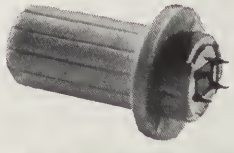
and a chest X-ray. Early recognition and vigorous treatment of acute myocardial infarction and its complications may promote rapid resolution of a neurological deficit that otherwise would become permanent. The prognosis for the stroke patient is worse if there is an associated myocardial infarction. Of course, arrhythmias, congestive heart failure, shock, or cerebral embolism may occur in the absence of myocardial infarction, but the end result may be the same if these problems are not detected early and treated efficiently. Decreased cerebral blood flow due to cardiac dysfunction may or may not be associated with actual cerebral vascular thrombosis. Cerebral embolism should be suspected as a possible cause of a transient cerebral ischemic attack or stroke when an arrhythmia is present, or if there is evidence of a recent myocardial infarction, or evidence of embolism elsewhere.

Other forms of heart disease which, when present, should alert the physician to their possible role in the production of acute neurological deficit are rheumatic heart disease with atrial fibrillation, bacterial endocarditis, and myocarditis. All are associated with an increased incidence of thromboembolic phenomena and can also be responsible for decreased cerebral blood flow in the same manner as described earlier.

Thus it is of utmost importance that the physician approach the problem of the patient who has had transient focal cerebral insufficiency or evidence of a stroke with a broad diagnostic perspective. A high degree of suspicion regarding the possible presence of etiologically related heart disease should be maintained. Careful history-taking, complete physical examination, and thoughtful selection of pertinent laboratory studies can be lifesaving or can prevent permanent neurological damage in the patient who has serious treatable heart disease as a source of his problem.

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health department

Mr. James H. Edwards Promoted To Administrative Health Officer-Nonmedical

Mr. James H. Edwards, Administrative Representative, has been promoted to Administrative Health Officer-Nonmedical, for the City Health Department's health districts. He will continue to work under the direction of John B. De Hoff, MD, Assistant Commissioner of Health for Local Health Services.

In his new post Mr. Edwards will provide community assistance on health matters, implement and coordinate district health programs, supervise the activities of administrative and technical personnel assigned to the districts and be responsible for the district buildings, facilities, and equipment.

Mr. Edwards has been a member of the City Health Department staff since 1948 when he was appointed a sanitarian. In 1956 he was promoted to senior sanitarian and in 1961 became a principal sanitarian. He has been Administrative Representative since March, 1967.

A graduate of Frederick Douglass High School, Mr. Edwards served as a First Lieutenant during World War II and participated in the invasion of Italy. Following military service Mr. Edwards attended Morgan State College, Boston University and The Johns Hopkins University.

He is a member of the National Association of Sanitarians, the Maryland Association of Sanitarians, and the Maryland Public Health Association. His office is in the Western Health District Building, 700 W. Lombard Street, telephone 837-2710.

Guidelines for Selecting a Day Nursery

Because of many inquiries, Mrs. Marion Persons, Chief of the Division of Child Day Care in the Baltimore City Health Department has issued some guidelines to assist pediatricians and other physicians in advising parents who may want to select a day nursery in which to enroll their children.

■ Visit the nursery under consideration before enrolling the child.

■ Determine if the day nursery has a current license issued by the Baltimore City Health Department. By law, each nursery must be licensed annually and the license posted in a conspicuous place. This license indicates that the day nursery has met the health and safety standards established by the Health Department.

■ Check the menus, the food preparation and service facilities. The food served should be appetizing, varied, and served in a family atmosphere.

■ Observe the center's daily program to assure that the child can benefit from this experience. Children should participate in activities in small groups led by adults who are suitably trained to meet the needs of young children.

■ See that the center has plenty of uncluttered

space with sturdy equipment and a variety of recreational and educational materials.

■ If transportation is provided by the facility, check the safety provisions. There should always be an adult in addition to the driver in each vehicle. Safety belts for all passengers are recommended.

Physicians are reminded that a child must be at least two years old before he can be enrolled unless approval for a younger child is given by the Commissioner of Health. Before enrollment each child must have a physical examination and immunizations against smallpox, diphtheria, whooping cough, tetanus, polio and measles. Physical examination record forms are provided by the Baltimore City Health Department and are obtained from the day-care center.

Further information on day nurseries may be obtained by calling Mrs. Persons or Mrs. Irma S. Kitchen, assistant chief of the division, at 752-2000, extension 2522 or 2523.

Expiration Date for Milk

Effective September 1, all milk sold in Baltimore City is to be plainly labeled "SELL BY" followed by the date after which the milk cannot be sold, for example, SELL BY 9-1. Thus, for the first time in Baltimore's history, the consumer is to be informed in plain language when the salability of the milk has expired and will therefore be assured of fresh milk.

Baltimore has had pasteurized dated milk for more than 50 years, since 1917. However, previously the container was labeled with the day of the week only. The new requirement is a revision of City Milk Code Regulation 53 that deals with labeling and was amended July 25, 1968.



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Chronic Bronchitis and Emphysema

A review of the literature on these two pulmonary conditions points to both their similarities and their differences. So serious is the effect of cigarette smoking on their development that the first step in control is prevention of cigarette smoking.

Chronic bronchitis may be defined on the basis of symptomology, while emphysema must be defined in morphologic terms.

Since differences of opinion on the respective roles of these conditions in the production of respiratory symptoms and in relation to prognosis have led to ambiguity in the use of the terms, it may be useful to mention some issues on which there is agreement.

Among the points of agreement are that chronic bronchitis is commonly associated with pulmonary emphysema; that airway obstruction, which may have its genesis partly in the bronchitic process and partly in the destructive changes of emphysema, is the principal incapacitating feature of both diseases; that derangement of ventilation-perfusion distribution may occur in patients who have little or no morphologic emphysema; and that the gas-tension derangement to which this maldistribution gives rise is usually the precursor of right ventricular failure, the most serious complication of both conditions.

One group of investigators who correlated pulmonary function during life with morphologic appearance after the patients' death found that the total lung capacity was a relatively poor indicator of the extent and severity of morphologic emphysema. The extent of the condition could be better measured by the departure of the residual volume from predicted numbers. CO transfer showed a satisfactory correlation with the extent of anatomic emphysema.

Weighing Morphologic Changes

The attempt to correlate arterial-blood gases with morphologic changes is made difficult by the possibility that hypoventilation may coexist with chronic bronchitis, and, because of the resulting chronic hypercapnia and hypoxemia, may play a more important part in determining cor pulmonale than the morphologic chronic bronchitis itself.

It may be premature to say that either chronic bronchitis or emphysema is responsible for degrees of ventilation/perfusion abnormality or dyspnea. Possibly patients at either end of the spectrum can be distinguished from each other, that is, the nonbronchitis, purely panlobular emphysema of the familial type should be distinguishable from that of the man with a severe bronchitic history, normal total lung capacity, normal pulmonary vasculature on X-ray examination, and normal CO diffusing capacity. When the conditions coexist, however, as is often the case, the effects of the two lesions cannot be apportioned.

In considering the natural history of chronic bronchitis and emphysema, it is necessary to attempt to describe the complex changes that occur in the lung from the first day a person smokes a

D. V. Bates, M.D., FRCP; *The New England Journal of Medicine,* March 14, 1968

cigarette or goes to live in an atmosphere of heavy urban pollution, to possible death 40 years later from respiratory failure or cor pulmonale.

First Effect of Smoking

The primary effect of cigarette smoking occurs at the level of the small bronchioles. Impairment of normal defense mechanisms against infection leads to slower convalescence from lower-respiratory infections than in the non-smoker. These early effects will be aggravated if the person lives in an area of high industrial air pollution.

After years of cigarette smoking (fewer years for the patient living in the city than for the one living in a clean atmosphere), the effect of the agents on the lung will have become measurable. Little sputum may be produced at first, the forced expiratory volume (FEV) may be nearly normal, the gas distribution will be impaired, and the residual volume somewhat increased. The FEV and total airway resistance are relatively insensitive to considerable changes in small airways. However, changes in peripheral airways are indicated by the fact that the dynamic compliance of the lung has become frequency-dependent, although recoil is normal, and by evidence of ventilation/perfusion abnormality.

Continued exposure to cigarettes and other pollutants leads to the next stage, in which considerable hypertrophy of mucous glands occurs. Sputum production also increases. During this time bronchioles are disappearing, and the ventilation/perfusion ratio may become more unfavorable in some regions of the lung. At this stage the lung is abnormally susceptible to any physical agent, and the bronchial tree as a whole has become hyper-reactive. Its cleansing mechanism must be impaired, and its resistance to any infection may be lower than in a normal lung.

Next there is breakdown of lung tissue, which occurs earliest in cigarette smokers and city dwellers. This usually begins at the respiratory bronchiole, presumably in alveoli that have been exposed to inspired material. This centrilobular emphysema is always accompanied by changes in bronchioles.

The failure of cell nutrition may not be localized to the center of the lobule but may occur more generally throughout the lung. When this occurs, and it may occur as a result of alpha$_1$-antitrypsin deficiency, the result is panlobular emphysema.

Effect of Normal Aging

Superimposed on these changes is the effect of normal aging of the lung whereby elastic recoil diminishes progressively, resulting in closure of small airways at a progressively higher lung volume and causing further maldistribution of ventilation.

In all types of emphysema there will be reduction in the number of terminal bronchioles. By this time the severe limitation of ventilation is not reversible. Atrophic changes in the walls of major bronchi may contribute to this final stage of the condition by causing their collapse during expiration.

In the control of chronic bronchitis and emphysema the most important aspect is the prevention of cigarette smoking.

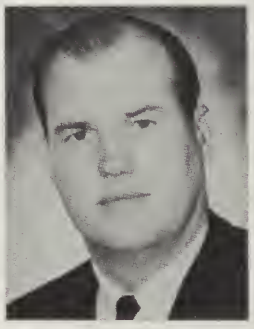
Although the rate of increased understanding of these conditions is not commensurate with the urgency of the problem, fortunately during the last ten years there have been important advances at least in understanding the complexity of the problems involved.



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News of Regional Medical Library Developments

Recently there have been meetings of representatives from the National Library of Medicine, the medical libraries in Virginia, Maryland, West Virginia and the District of Columbia for the purpose of discussing the status quo of regional library services in this area.

The first meeting on July 29, 1968 was attended by Miss Hilda Moore, Director, Health Sciences Library of the University of Maryland, Mr. Alfred Brandon, Director, Welsh Memorial Library and Mrs. Elizabeth Sanford, Librarian, Medical and Chirurgical Faculty, all of Baltimore, representing the three largest medical libraries in the State of Maryland. Mrs. June Huntley, Librarian, Medical College of Virginia, Richmond, Miss Margaret O'Byrne, Librarian, Georgetown University Medical School, Washington, D. C., Miss Isabelle Young, Librarian, George Washington University School of Medicine, Washington, D. C., and Miss Roberta McLemore, Librarian, Howard University Medical School, Washington, D. C., also attended. This group was joined by a representation from the departments of National Library of Medicine which are directly concerned with the problems of regional library operations.

Various facets of the program were presented by National Library of Medicine personnel. This was followed by a discussion of the survey made in Virginia and the participation of the Virginia libraries in services to other medical or paramedical libraries in the state. An extensive questionnaire was sent to these libraries to determine their resources and needs. From this an evaluative criteria will evolve upon which future needs for services can be based.

After discussing the procedure for implementing such a questionnaire-survey, Mr. Sam Waters, Chief of Reference Service Division, National Library of Medicine, who moderated the discussion, called on others for ideas about procedures to be followed in Maryland and the District of Columbia in order to obtain the same type of information in these areas.

It was mentioned that the American Hospital Association had recently circulated a very lengthy questionnaire to hospital libraries and that the AMA, in cooperation with the National Library of Medicine and Case Western Reserve, also was making a comprehensive study of medical libraries nationally. The meeting ended with an agreement that everybody would go home, study the situation and come back to another meeting prepared to make further study and plans for operation of a cooperative regional library program.

The next meeting was held on September 19, 1968 at the National Library of Medicine with a larger group attending, including Alderson Fry, Librarian, University of West Virginia Medical School, Morgantown, West Virginia, and William Moll, Librarian, University of Virginia Medical School, Charlottesville, Virginia. A number of new faces from the National Library of Medicine also appeared, including Miss Charlotte Kenton, who will be Regional Medical Librarian for the

Mid-Atlantic Area. This includes Maryland, Virginia, West Virginia, and the District of Columbia. Because of our location, the headquarters of the National Library of Medicine in Bethesda, acts as headquarters for this area.

A culmination of these meetings will probably be a summary of the medical library situation in the Mid-Atlantic Regional Library area, with the National Library of Medicine allowing requests originating within its geographic boundaries to receive priority treatment.

Watch for exciting new developments in Interlibrary Loan and Medlars search procedures.

December 3, 1968 is the date of the Tri-State Hospital Association meeting in Washington during which the Baltimore Hospital Association will sponsor a luncheon and panel discussion. Hospital librarians particularly should plan to attend and hear later news about the regional library in Maryland.

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Cost of Health Quackery Greater Than Health Education, Research

Health quackery costs more each year in the United States than the entire cost of health education, the president of the American Medical Association said recently.

"In addition," Dwight L. Wilbur, MD, told the Fourth National Congress on Health Quackery, "it is more than the cost of all medical research done in this country."

Estimates of the cost of quackery are, at best, educated guesses, the San Francisco physician said, adding:

"The figure quoted most often is a billion dollars a year. That is the figure used by governmental spokesmen. However, they admit that it includes only the quackery schemes in which the federal government has a direct interest—in other words, those involved in *interstate* commerce.

"We feel confident that at least another billion dollars is spent for quackery on an intrastate basis."

And, said Dr. Wilbur, "if the forces opposing quackery, such as those represented in this room, do not take timely and effective action, there is a strong possibility that tax money collected from all the people of this nation will be spent to support and provide unscientific, cultist treatment for citizens of our country.

"Right now, a committee appointed by the Department of Health, Education, and Welfare, at the direction of Congress, is studying the feasibility of including chiropractic services under federal health care programs such as medicare and medicaid. The very fact that such a possibility could be studied proves the effectiveness of the chiropractic lobby in Congress."

Dr. Wilbur reminded the audience at the Drake Hotel of the statement of policy on chiropractic which AMA's House of Delegates adopted in November 1966. It says in part:

"It is the position of the medical profession that chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease."

It is incomprehensible, Dr. Wilbur said, "that thousands of people won't let anyone but a bonded and certified technician touch their television set, insist that the school board maintain a strict certification program for teachers, refuse to take their automobile to any repairman except at the dealership where they bought it, check all door-to-door salesmen through the Better Business Bureau before buying a product, but then—when they come down with the flu or get recurring headaches or have severe indigestion—go looking for help to a chiropractor."

An internist and gastroenterologist, Dr. Wilbur is chief of medical service at French Hospital in San Francisco, is on the staff of several other Bay area hospitals, and is clinical professor of medicine at Stanford University.



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woman's auxiliary

Highlights of the Semiannual Meeting

The Semiannual Meeting of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland convened at the Diplomat Motor Hotel in Ocean City, Maryland on Friday, September 6th. **Mrs. H. Leonard Warres** presided.

The meeting opened with a prayer and the Auxiliary's new pledge. **Richard A. Young, MD,** Auxiliary Advisor and Chairman of Public Relations Committee, Medical and Chirurgical Faculty, greeted the assemblage which was attended by 60 members and officers. Guest speaker, **Vincent O. Eareckson, Jr., MD,** Easton, Maryland, recipient of the Community Service Award in April 1968, spoke on "The Doctor in Community Service." His inspirational talk was based on his experience in initiating and setting up a home for delinquent boys, and his constructive contacts with people and businesses assisting him in his efforts.

One of the important items of business was the election of a new nominating committee as follows:

Mrs. M. McKendree Boyer, Chairman (Montgomery County)
Mrs. Albert Cooper (Member-at-Large)
Mrs. James Garey (Harford County)
Mrs. Daniel Anderson (Wicomico County)
Mrs. R. Kennedy Skipton (Prince George's County)

Mrs. Warres reported that since taking office in April, she had addressed the House of Delegates of Med-Chi, held two meetings of the Executive Board, attended the lovely annual meetings of five county auxiliaries (Cecil, Harford, Baltimore, Washington, and Wicomico) and installed their officers. She had also attended two meetings of WASAMA, and all meetings of the National Auxiliary to the West Virginia Medical Society at the Greenbriar in White Sulphur Springs in August. She planned to attend the Pennsylvania State Auxiliary meetings in Pittsburgh in September, the National meetings in Chicago for all State Presidents and Presidents-Elect in September and October, and the Allegany County Auxiliary meeting in Cumberland in November. She attended the showing of a Nurse-Recruitment TV program which is to be made into a short movie under the financial co-sponsorship of the Nurses Association, Public Health Department, and the Baltimore City and Maryland State Medical Auxiliaries, and helped arrange for auxiliary women to man the Medical Seminar on Sports in Catonsville on August 14. She has complied with all requests of our National Auxiliary for information, and has answered all correspondence, met and conferred with all officers and chairmen either by phone, mail or in person; and helped assemble lists of all County and State Auxiliary Officers and Chairmen in handsome new directories in our State colors, with a calendar of the year's many activities included.

Package Programs

The AMA Woman's Auxiliary has developed excellent "**Package Programs**" and health education presentations to help you focus public attention in your community on meeting urgent health needs. Each package consists of a carefully researched folder of resource material to enable your auxiliary to sponsor a timely health education program for community groups. Included in each folder are:

1. A Procedure Guide.
2. A Fact Sheet.
3. A Question-and-Answer Sheet to be given to each member of the audience.
4. A Source List of recommended films.
5. An Authoritative Speech which can be presented by the program moderator.
6. One or more pamphlets suggested for distribution.
7. A Tally Sheet to be filled in and mailed to national headquarters after the program has been presented.

The eight "Package Programs" in the series now available are:

Teen-age Venereal Disease
Youth, Health and Fitness
Mental Health of Children
Health Careers
Immunization
The Block Mother Plan
Homemaker Service
Sex Education

To order your "Package Program," consider which program your auxiliary can profitably present this year and check with your medical society and public health leaders to ascertain that there is a need to sponsor such a program in your community. Then order from: Woman's Auxiliary to the AMA, 535 N. Dearborn St., Chicago, Illinois 60610. Give the title of the program, the name of your auxiliary, and the address of the person to whom the "Package Program" should be sent. Only one on a particular subject per auxiliary, please. DO LET'S TRY TO DISSEMINATE THIS VERY WORTHWHILE INFORMATION.

NMA Woman of the Year

Mrs. Emerson Walden, Chairman of Revisions and Resolutions, Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland, was mentioned in the AMA News for her outstanding work in the field of sex education, which won her the award of Woman of the Year in the NMA Auxiliary.

Invitation For Prospective Members-At-Large

You are most cordially invited to join the ranks of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland as a Member-at-Large representing your county. "Members-at-Large are wives of physicians in a county where no auxiliary exists and may be Active or Associate depending upon the physician's membership status." (By-Laws) If you are eligible and willing to join you need only to complete the following form, attach your check in the amount of $4 (payable to Woman's Auxiliary, Medical and Chirurgical Faculty), and return to Mrs. Joseph Workman, 162 Ligdon Road, Ellicott City, Md. 21043. We welcome you.

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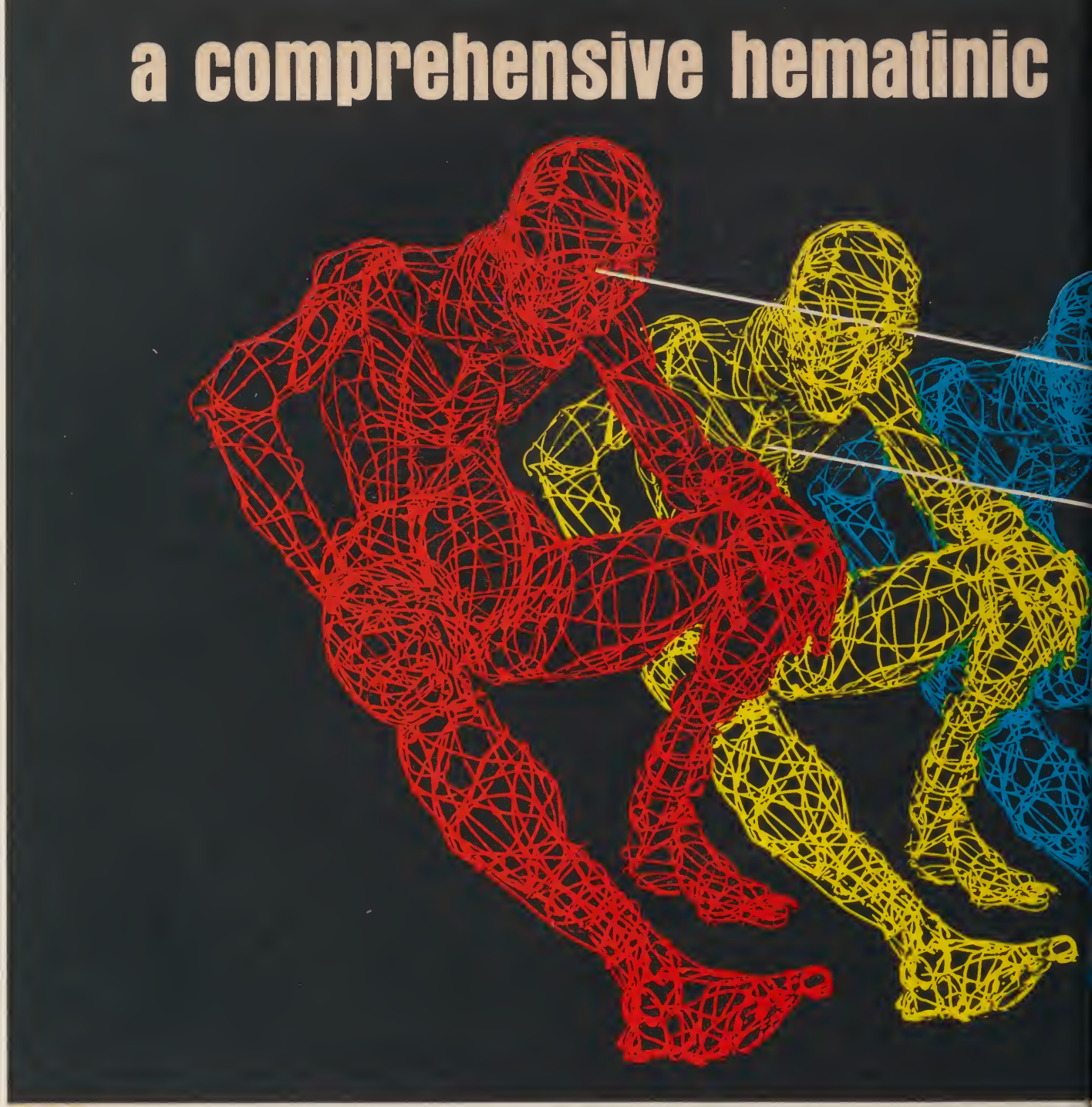
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Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

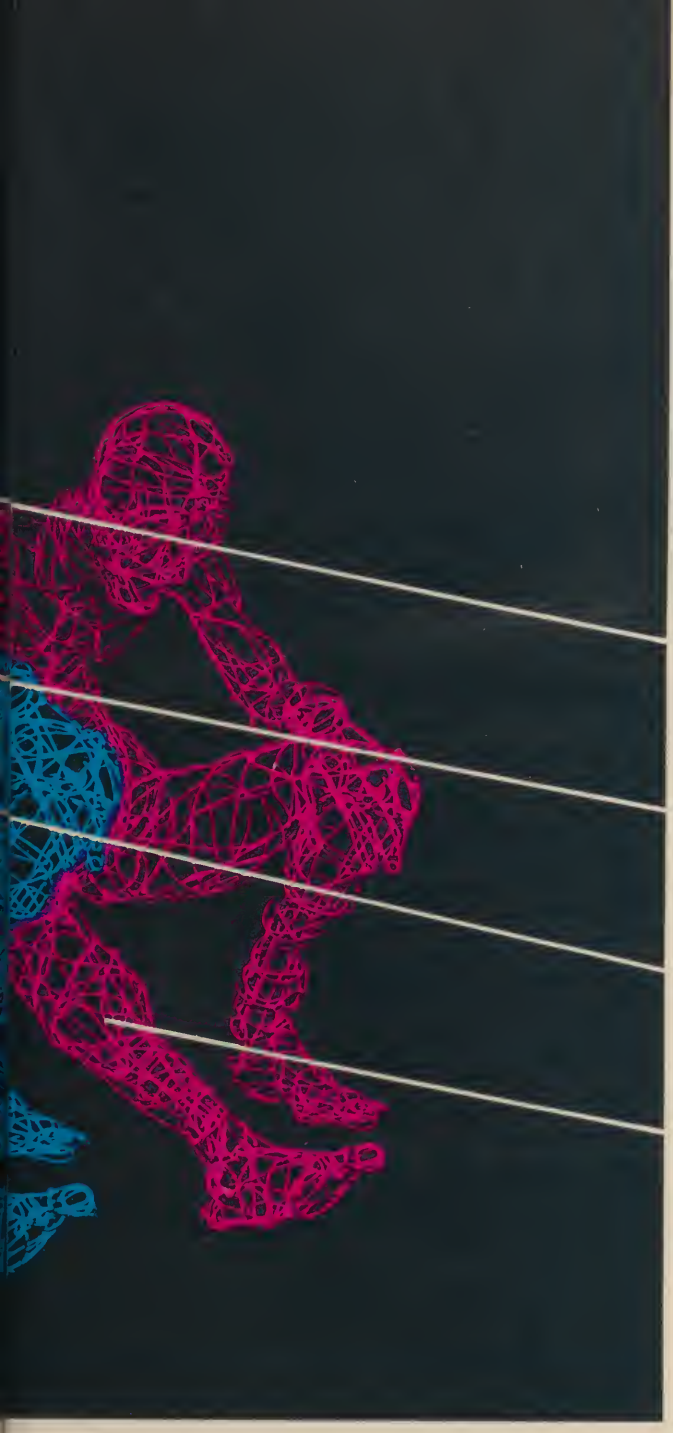
Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequate vitamin B_{12} therapy may result in hematologic remission but neurological progression. Adequate doses of vitamin B_{12} (parenteral or oral with potent intrinsic factor as in Trinsicon® [hematinic concentrate with intrinsic factor, Lilly]) usually prevent, halt, or improve the neurological changes.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potentiation of absorption of physiological doses of vitamin B_{12}. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B_{12}, may be necessary. No single regimen fits all cases, and the status of the patient observed in follow-up is the final criterion for adequacy of therapy. Periodi



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linical and laboratory studies are considered essential and are ecommended.

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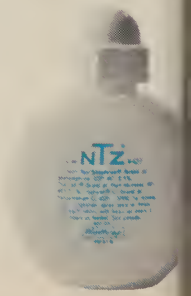
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NOVEMBER 22, 1968—12:30 P.M.

MELANOMA AND CANCER OF THE SKIN

Joseph W. Burnett, MD
Assistant Professor of Medicine In Dermatology
University of Maryland School of Medicine

A discussion of skin malignancies including epitheliomas and myomas will be made. The pathogenesis, clinical manifestations, complications, prognosis and methods of treatment will be discussed. The advantage of treatment programs such as surgical excision, radiation, chemotherapy, cryosurgery and chemosurgery will be made. Some new advances of pathogenesis of melanomas will be outlined.

Sponsor: Frederick Memorial Hospital
Replays: Monday, November 25, 1968 12:30 P.M.
Wednesday, November 27, 1968
9:00 A.M., 2:00 P.M., 8:00 P.M.

NOVEMBER 29, 1968—12:30 P.M.

ASTHMA

Thomas E. VanMetre, Jr., MD
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine

Asthma ranks high as a cause of chronic respiratory disease. Care of patients with this disease frequently taxes the skill of the practitioner. Aspects of pathophysiology, inducing factors, complications and management will be explored and discussed.

Sponsor: Maryland General Hospital
Replays: Monday, December 2, 1968 12:30 P.M.
Wednesday, December 4, 1968
9:00 A.M., 2:00 P.M., 8:00 P.M.

DECEMBER 6, 1968—12:30 P.M.

DIAGNOSTIC PROBLEMS IN RHEUMATOID ARTHRITIS

Alexander S. Townes, MD
Assistant Chief of Medicine
Baltimore City Hospitals

The diagnostic features of rheumatoid arthritis will be discussed briefly reviewing the characteristic clinical features of the articular and extra-articular manifestations of the disease. There will be a brief review of other syndromes which may be confused with rheumatoid disease and how one may differentiate them clinically from rheumatoid arthritis. This discussion will also include a resumé of the clinical significance and interpretation of serologic tests for rheumatoid factor.

Sponsor: Washington County Hospital
Replays: Monday, December 9, 1968 12:30 P.M.
Wednesday, December 11, 1968
9:00 A.M., 2:00 P.M., 8:00 P.M.

DECEMBER 13, 1968—12:30 P.M.

MANAGEMENT OF RHEUMATOID ARTHRITIS

A. Lewis Kolodny, MD
Director, Department of Rheumatology
North Charles General Hospital

The treatment of various stages of rheumatoid arthritis will be discussed. Practical aspects of proper therapeutic modalities such as drugs, physical medicine and surgical correction will be presented. Furthermore, emphasis will be placed on early recognition and treatment of this disease.

Sponsor: Anne Arundel General Hospital
Replays: Monday, December 16, 1968 12:30 P.M.
Wednesday, December 18, 1968
9:00 A.M., 2:00 P.M., 8:00 P.M.

DECEMBER 20, 1968—12:30 P.M.

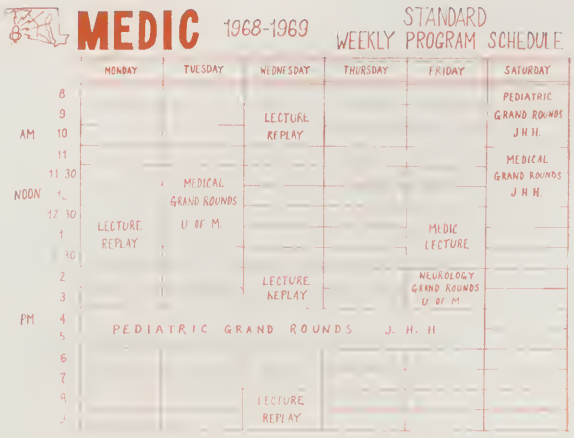
ANKYLOSING (RHEUMATOID) SPONDYLITIS

Harry F. Klinefelter, MD
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine

This disorder most commonly afflicts young men. Early diagnosis is mandatory for optimum therapeutic results. This presentation will stress these points and discuss appropriate therapy and the beneficial effects that can be obtained.

Sponsor: Greater Baltimore Medical Center
Replays: Monday, December 23, 1968 12:30 P.M.

(Continued next page.)



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Franklin Square, Baltimore
Frederick Memorial, Frederick
Greater Baltimore Medical Center, Towson
Harford Memorial, Havre de Grace
The Johns Hopkins, Baltimore
Kent & Queen Anne's, Chestertown
Keswick, Baltimore
Lutheran, Baltimore
Maryland General, Baltimore
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Provident, Baltimore
Rosewood State, Owings Mills
Sacred Heart, Cumberland
St. Agnes, Baltimore
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The Department of Allied Medical Professions and Services

For more than 30 years the American Medical Association has worked with medical specialty associations and health professions associations to establish mutually acceptable educational programs in the allied fields.

Because of the more sophisticated roles being cast for members of the allied professions in the delivery of health care and the need to further solidify existing programs and establish universal educational standards for already existing or emerging occupations, the AMA is strengthening its efforts in this area.

Carrying out this function at the staff level is the Department of Allied Medical Professions and Services, an arm of the Council on Medical Education. Elevated to departmental status two years ago, as part of the newly created Medical Education Division, it is comprised of ten persons, including four health professionals.

The department provides staff services to the five-member (three physicians and two health educators) AMA Advisory Committee on Education for the Allied Health Professions appointed in November, 1967, and is chiefly concerned with reviewing and updating existing essentials for schools or courses in nine allied professions or occupations; preparing guidelines to determine the need for new occupations and development of new essentials in collaboration with other professional associations; and developing educational "ladders" which define educational levels for allied occupations and which, eventually, pave the way toward greater vertical mobility in the health field. The department also is concerned with all legislation involving education for the health professions.

Currently, the AMA, in cooperation with medical specialty groups and health professions associations, accredits schools or courses in nine career categories—physical therapist, occupational therapist, medical technologist, cytotechnologist, medical record librarian, medical record technician, X-ray technologist, inhalation therapist and certified laboratory assistant.

Within the past year these educational programs have produced nearly 11,000 graduates. Enrollment in 1,187 approved schools presently exceeds 19,000. During the year, the staff resurveyed, through on-site evaluations, 373 (18%) of the approved programs.

Because of the need for universal training standards required by the medical profession, it is almost certain that additional existing or emerging professions will come under the umbrella of AMA accreditation.

In collaboration with the other professional associations concerned, the AMA has developed essentials of an accredited school of radiation therapy technology which have been approved by the Council on Medical Education and will be transmitted to the House of Delegates at the AMA Clinical Convention in December in Miami, Fla. Also under consideration are essentials for educational programs for nuclear medicine technologists and medical assistants and potential development of essentials for teaching programs for physicians' assistants and educational programs for electroencephalography technicians.

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Applications are being accepted by the American Heart Association for research support for the fiscal year, July 1, 1969 to June 30, 1970 or July 1, 1969 through June 30, 1971. Deadline for applications is December 1, 1968.

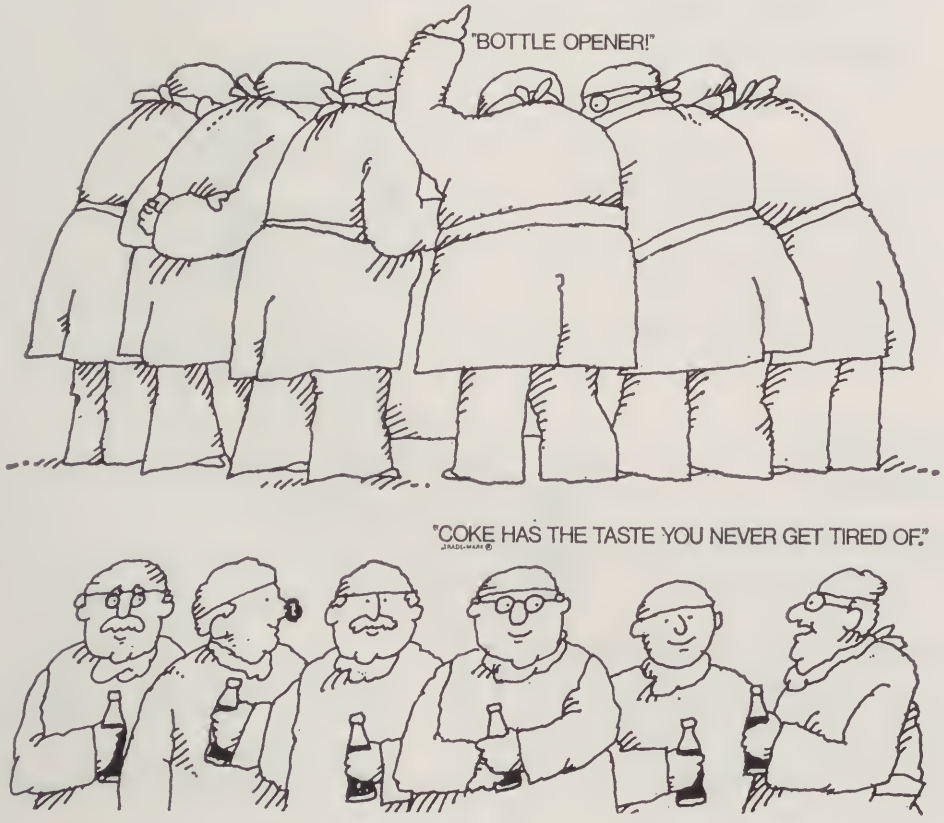
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GRANTS-IN-AID: To support an investigator's research project in a qualified non-profit institution in Maryland.

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During the summer 55 talented inner-city students participated in the Health Science Careers Program directed by David Levy, MD, at The Johns Hopkins Medical Institutions.

All students were carefully screened before they were admitted into the program. In most cases they were selected by the head of the science department in their high school or by their guidance counselors. Then they were interviewed by a member of the program at Hopkins.

In addition to receiving on-the-job experience, the students in the health science careers program attended weekly seminars.

At least 70% of this summer's participants are now planning to go to college.

Neighborhood Youth Corps

Nearly 170 teen-agers worked this summer at The Johns Hopkins Hospital in the Neighborhood Youth Corps Program.

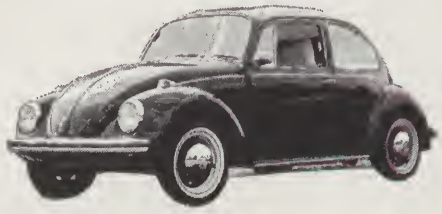
The program provides work experience, encourages the participants to remain in school by providing needed funds, and gives them a broad view of health careers and possible jobs for the future. The NYC tries to place them in areas of interest to them.

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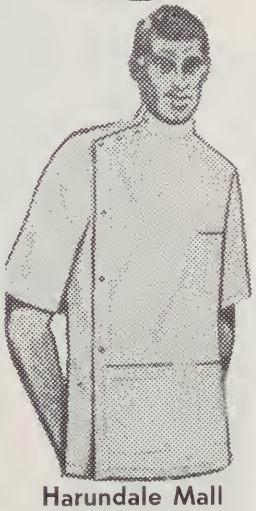
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Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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BOTH PATIENT, QUACK MAY BE DELUDED IN HEALTH QUACKERY, FDA OFFICIAL SAYS

Medical quackery is able to thrive because of delusion by all elements of society, rich or poor, contends an official of the Food and Drug Administration.

Douglas C. Hansen, Chicago Regional Assistant Commissioner of the FDA, said today: "There is no doubt in my mind that the common denominator of quackery is delusion, either on the part of the patient, the quack, or, not infrequently, both."

Mr. Hansen pointed out, however, that "this does not mean that we should leave out the profit motive, which in most cases is the most important consideration that gets the quack into business in the first place.

"And in the past few years, these profits have run into tens of millions."

He spoke on drug and device quackery at the National Congress on Health Quackery, sponsored by the American Medical Association and National Health Council, at the Drake Hotel.

Mr. Hansen said "quackery is not just taken by the poor and the uneducated, but also by the educated, the middle class, those groups which we tend to think of as the backbone of our society.

"Indeed, in the six decades during which the FDA has fought a continuing battle against quackery, we have found that education by itself is by no means a protection against the infinite variety of schemes which defraud people of their money and health every year."

The common denominator that "explains this extraordinary situation in our society," he said, is the "element of delusion."

"In most cases," Mr. Hansen said, " . . . it is the patient who is deluded; but in some cases even the quack himself has convinced himself of his own extravagant claims to superior scientific knowledge. This is certainly often the case with the food faddist."

Noting the overuse of vitamins, he said "perhaps over $400 million are being spent needlessly for therapeutic vitamins. Well over $100 million a year more, according to an investigative committee of the U.S. Congress, go to buy false and fraudulent weight-reduction schemes, pills and potions."

The operations of the quack can have various consequences, from ludicrous to deadly serious, Hansen warned. "The overweight homemaker who uses an electric massager to get some of her fat off will be disappointed that her dresses continue to be size 24—but no greater harm will be done" unless the overweightness endangers her health.

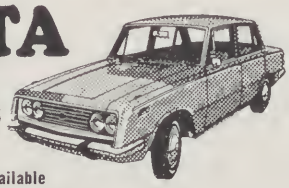
"But the cancer patient who resorts to the Krebiozen, Koch, Hoxey, or Laetrile treatments may well be sentenced to death. . .," Hansen said.

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Legislators Should

The practice of chiropractic should be prohibited, and its personnel retrained for other occupations, New York author Ralph Lee Smith said recently.

Addressing the Fourth National Congress on Health Quackery, at the Drake Hotel, Mr. Smith urged creation of "an orderly program for withdrawing chiropractic licenses," adding:

"As part of this program, consultations should be held between state legislators and the scientific community to discover where needs exist for persons in physiotherapy, physical rehabilitation, and other fields that make use of paramedical personnel."

Those chiropractors wishing to remain in the field of health should be offered full retraining in one of these areas, he said. Those wishing to leave the field, he said, should have a "chiropractor's GI Bill" for retraining in some other field.

Mr. Smith has written several books, including *The Health Hucksters,* and has done articles for many of the major national magazines. He visited a number of chiropractic schools and clinics during the past four years in acquiring material for his latest book, *At Your Own Risk: The Facts About Chiropractic,* which is scheduled to be published in a few months.

A retraining program, he told the American Medical Association/National Health Council conference, "is the least that the states can do in view of the central responsibility that they bear toward both chiropractors and the public for

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Ban Chiropractic

Author Says

creating the current situation. It should not have happened in the first place; and, furthermore, when the legislatures passed the licensing laws, they did it with the full knowledge that chiropractic was and is without scientific foundation or support. When public servants, some misguided and some cynical, fail so completely in their most rudimentary responsibilities, there is always a price to pay."

From its infancy, Mr. Smith said, chiropractic has been politically precocious and politically successful. An important factor in chiropractic's present position, Mr. Smith said, "is that it succeeded in getting licensure laws through 32 of the nation's 48 rurally-dominated state legislatures by the year 1925, almost before the modern era of health care and health legislation began."

Then, he said, "they conducted intensive campaigns to reduce the remaining legislatures one by one. By now Louisiana and Mississippi are the only states that do not license chiropractors, and the legislatures of these two states are under heavy chiropractic siege."

Nor should the public be blamed for failing to realize that chiropractic has no scientific foundation, he said: "People should be able to assume, and obviously do assume, that a state-licensed health practitioner using the title 'doctor' is practicing a valid healing art. It is time to place ultimate responsibility for both the problem and its solution where it properly belongs—on the doorsteps of the state legislatures."

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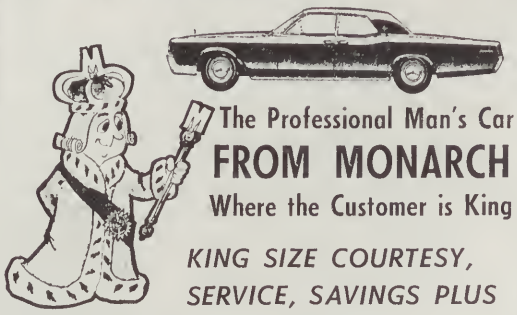
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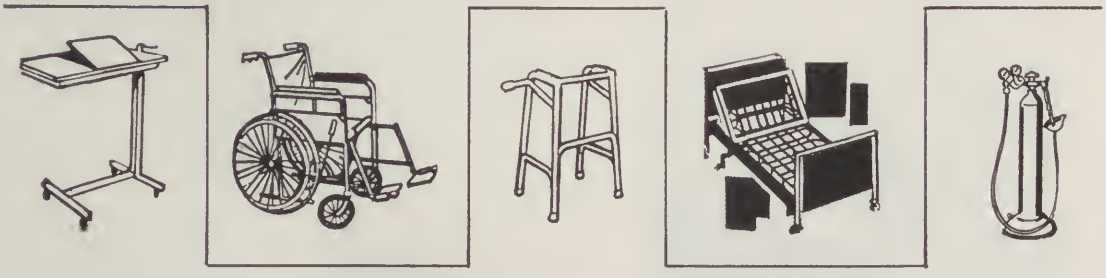
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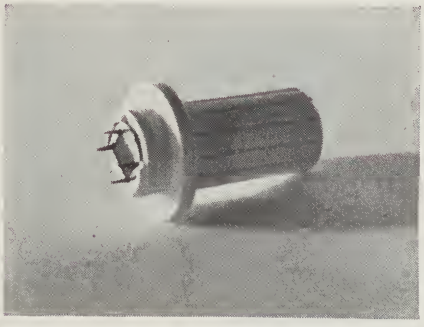
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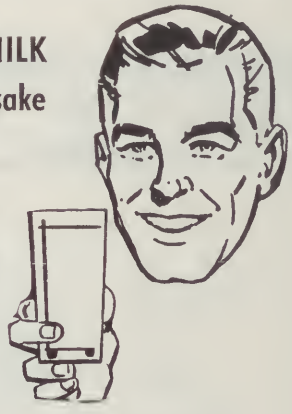
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Baltimore City Medical Society

MEETING NOTES

Ten members of the Board of Directors of the Baltimore City Medical Society attended the meeting held October 8, at 4:30 PM at 1211 Cathedral Street. The meeting was called to order by Raymond C. V. Robinson, MD. The minutes of the meeting of September 3 were approved.

Lester Wall, MD, on behalf of the Baltimore City Medical Society Section on Internal Medicine, brought to the Board's attention the policy of the Medical and Chirurgical Faculty regarding laboratory services and the role of the physician. There are many portions of this policy, which appeared in the February issue of the *Maryland State Medical Journal,* which the Internal Medicine Section feels should be reconsidered. After some discussion by the Board, it was decided that Gordon Cader, MD, who was also present at the meeting, and a subcommittee of the Internal Medicine Section present their ideas in the form of a resolution to the Board of Directors. If the Board approves, the resolution can then be submitted to the Medical and Chirurgical Faculty House of Delegates.

James K. Insley, MD, was voted a refund of his 1968 dues because of illness.

Letters from several agencies soliciting money from the Society were read. It was decided that although the Society supports the efforts of such agencies it does not feel it can provide financial support.

Since 95% of the outpatient service dispensed in the State of Maryland under Title 19 occurs in Baltimore City, the representatives from the Society to the State Liaison Committee were reminded that any policy recommendations concerning this service should be considered by the Board of Directors, and the Baltimore City Medical Society.

Henry Bongardt, MD, who has retired from active practice was elected to Emeritus Membership.

A request from the Health and Welfare Council for recommendations for nominees for the Organizational Achievement Award was given consideration. Emmanuel A. Schimunek, MD, suggested that the Baltimore City Medical Society recommend itself for this award on the basis of its extensive television educational programs presented by the Committee on Public Medical Education and Public Relations.

The meeting adjourned at 6:00 PM.

Montgomery County Medical Society

Marvin I. Mones, MD, President of Montgomery County Medical Society, has announced that the Medical Society in its first meeting of the season, September 17, conducted at the Washington Golf and Country Club, recognizing the severe health hazard of cigarette smoking passed a strong recommendation that the hospitals in the County no longer make cigarettes available on hospital premises. The Public Health Committee believes this action is necessary to safeguard the health of the community.

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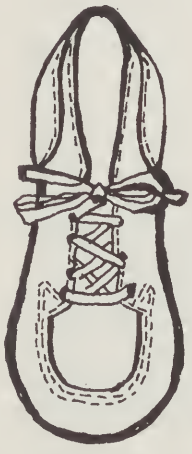
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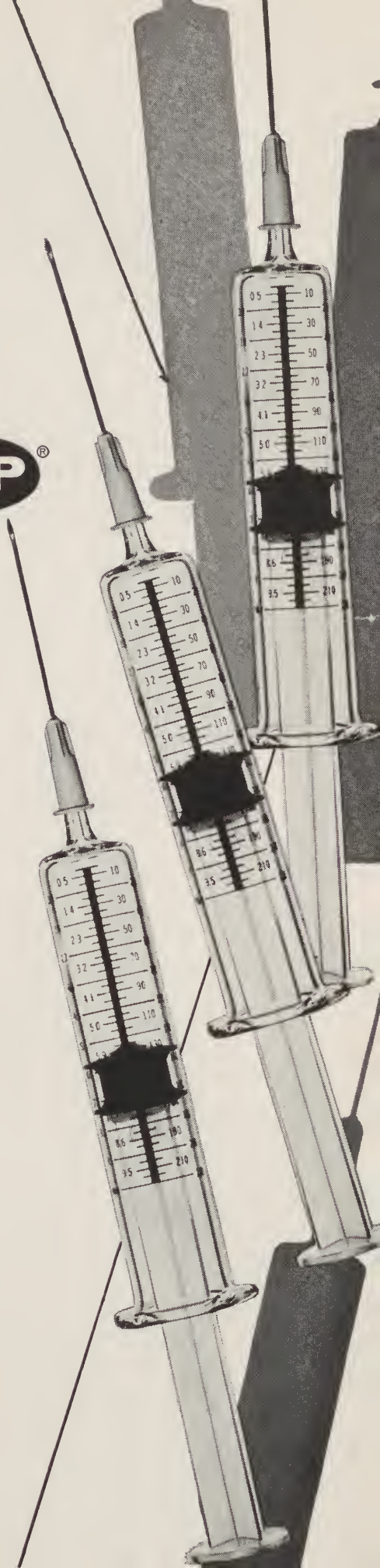
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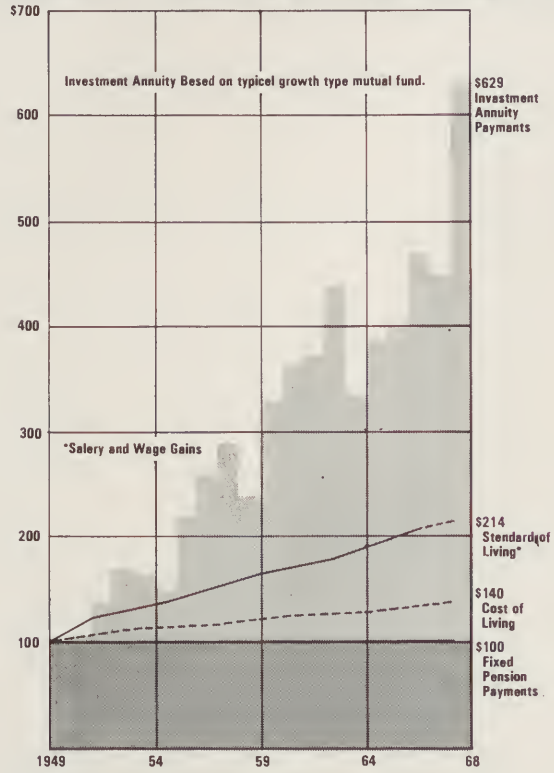
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executive secretary's newsletter

December, 1968

EDUCATIONAL BOOKLET ON COMMISSION ON MEDICAL DISCIPLINE

An educational pamphlet dealing with the Commission on Medical Discipline is "in the works." The pamphlet will include an updating of what constitutes ethical and unethical conduct; as well as brief summary examples of incidents that clarify the general conditions that could lead to probation, revocation or suspension of a medical license.

Copies will be mailed to all members as soon as they become available.

1969 DUES BILLS

1969 Dues Bills have been mailed to all members. Physicians are reminded that payment of dues must be made BEFORE JANUARY 31, 1969, in order to be eligible for Physicians' Defense.

The Council has ruled that strict interpretation of the Faculty's Bylaws precludes authorization of this benefit of membership if members do not comply with this Bylaw requirement.

With an increasing number of cases being reported by Maryland physicians (including higher and higher awards, when negligence has been established) members are urged not to overlook the valuable help and assistance afforded through legal defense by the Faculty.

COPIES OF PROPOSED LAW AVAILABLE

Copies of the "model" legislation dealing with the Incorporation of Self-employed Persons (including groups or associations) are now available.

Arrangements have already been made for its introduction at the 1969 General Assembly. Details may be obtained through the Faculty office.

PUBLIC SPEAKING SEMINAR

A one-day course in public speaking will be conducted through the auspices of the Faculty and the American Medical Association on

THURSDAY, MARCH 13, 1969

at 9:00 a.m. to 5:00 p.m. Details may be obtained

PUBLIC SPEAKING SEMINAR

through the Faculty office. Requests for information and registration data should be mailed as promptly as possible. Registration is limited to 30 persons.

RESOLUTIONS FOR 1969 ANNUAL SESSION

Resolutions for consideration at the Faculty's Annual Meeting, April 11, 1969, must be received in the Faculty office prior to FRIDAY, FEBRUARY 14, 1969. Article XI, Section 23, of the Faculty's Bylaws stipulates this requirement for resolutions submitted by other than members of the Faculty's Council or Committees.

1969 SEMIANNUAL SESSION

The 1969 Semiannual session will be held on September 5 and 6, 1969, at the HERSHEY HOTEL, HERSHEY, PA. A change in the location of the Semiannual session is due to the lack of adequate facilities in Ocean City.

INTERESTING MEDICAID FIGURES

The Hospital Council of Maryland, Inc., at its Annual Meeting in November, released some revealing figures:

In 1961, the physician portion of the Medicaid budget for the State was 0.80 dollars or 7.9%; compared to 11.4% for pharmacy services, 78.8% for hospital services and 1.7% for dental services.

In the fiscal 1970 budget request, the same figures are:

Physicians' home and office, 5.5%; physician, in-hospital, 7.6%; hospital, 41.5%, pharmacy, 9.8%, dental, 6.6% and nursing homes 24.7%.

Totals for the same two years are $10.22 million for 1961; and $100 million for the 1970 fiscal year budget request. Federal participation has increased from $7,317,000 (1966) to $44,443,000 in fiscal 1970. The State's share has changed from $21,451,000 in 1966 to $55,430,000 in fiscal 1970.

John Sargeant

Executive Secretary

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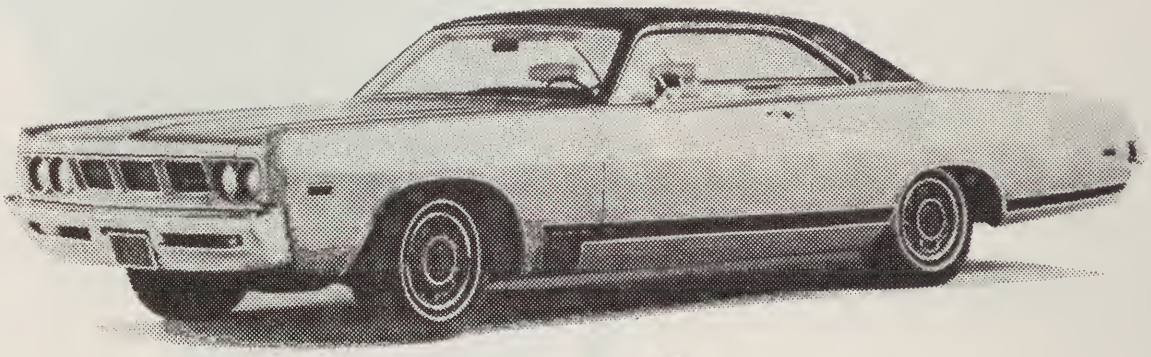
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THE MONTH IN WASHINGTON

Three-fourths of the Medicare Part B carriers now are using individual physician fee profiles in determining reasonable charges.

The Social Security Administration said that these carriers, a total of 36, collectively process 80% of the medicare bills submitted by physicians. Prevailing fees continue as a major factor in the reasonable charges determined by the carriers.

The remaining 14 carriers, which have not yet fully developed the individual physician fee profiles, or the computer capacity for using them, are employing other interim techniques. Some use, in addition to prevailing fees, fee schedules; others, relative value scales or similar techniques in determining reasonable charges.

The medicare law calls for individual determinations by the carrier which take into account the customary charges of the physician and the prevailing charges in the locality for similar services. In addition, carriers must assure that the charges determined to be reasonable for medicare beneficiaries are not higher than the charges for comparable services under comparable circumstances to their own policyholders and subscribers, according to the SSA.

Payment is to be made on the basis of the lowest of those three criteria, or the physician's actual charge, if that is still lower, the SSA said.

"Making a reasonable charge determination involves checking each bill against compiled data on the individual physician's customary charges for similar services and the prevailing level of charges for such services in the locality in which the physician practices," the SSA said.

"The development of physician fee profiles," according to Thomas M. Tierney, medicare's director, "present a unique challenge to both the SSA and the contracting carriers. At the time of medicare's enactment, there was no industry-wide pattern in the health insurance field on the approach to reasonable charge determination.

"There is evidence now that the successful application of the guidelines interpreting the medicare reasonable charge provisions, including the required development and use of individual physician fee profiles, is leading to a more systematized and consistent approach to the payment of physicians' bills in the health insurance field generally."

The medicare hospital deductible will be increased from $40 to $44 January 1, 1969. The law specifies that if an annual review shows that hospital costs have changed significantly, the hospital deductible amount must be adjusted for the following year. Necessary increases in the deductible amount are to be made in $4 steps to avoid small annual changes.

* * *

The shortage of physicians, particularly general practitioners, was cited in a government report as a factor in the increase in physicians' fees since World War II.

The Bureau of Labor Statistics (BLS) reported that charges for medical care, including hospitalization, had risen at an annual rate of 3.9% since World War II while prices of all consumer items combined, advanced at a rate of 2.6% per year. The bureau said that medical care prices had risen at a faster rate in recent years, 6.6% in 1966 and 6.4% in 1967.

The report said that physicians' fees, while not advancing as rapidly as hospital charges, had more than doubled in the past ten years. Hospital charges more than quadrupled.

"The rise in physicians' fees during the 1946-67 period is partially due to the general rise in price levels and to the physicians' need for increased income to cover his personal

and business costs," the report said.

"This is especially true for the past two years. Doctors have tended to attribute their higher fees in recent years to the general economic conditions and the higher cost of doing business. Nevertheless, some charges clearly reflect the shortage of doctors. With an overload of patients, physicians in some cases have tried to discourage the practice of making house calls by raising the rate for such a service to a level that few patients are willing to pay. The post-war emphasis on medical specialists has also helped to boost physicians' fees since general practitioners have become scarce, and specialists, with their extra training, are able to command higher fees."

The number of GP's declined from 73,593 in 1963 to 68,920 in 1967 while the number of physicians in all categories increased from 276,475 to 308,475.

The BLS conceded that its reports on health care costs do not give adequate consideration to improvements in the quality of medical care as reflected in longer life spans, improved and more efficient techniques for treatment, shorter hospital stays, etc.

"It is obvious that there are many problems of definition and measurement to be solved before any progress can be made in introducing appropriate methods of measuring medical care price changes in a more meaningful way," the report said.

Two other federal developments dealt with medical care for the poor. The Board of Medicine of the National Academy of Sciences announced the start of a comprehensive, two-year study titled "Health and the Poor." A joint state-federal task force reported on its study of costs for medical and public assistance programs.

The Board of Medicine named a special panel for its study which will cover: the quantity and quality of medical care the poor now receive; existing federal programs, such as medicaid, anti-poverty projects, maternal and child health programs, and community immunization programs; future needs and possible programs; and the economics of medical care for the poor.

Recommendations of the joint task force to the Department of Health, Education and Welfare included:

- States should draw samples to produce information on the current utilization of each of the medical care services offered, and their costs. The sample should provide data on how much of these costs are borne by the medical assistance program, and the amount that comes from other sources.

* * *

President Johnson signed into law a bill providing for tougher penalties for illegal traffic in amphetamines and barbiturates. LSD also is covered specifically.

The new law makes illegal possession, manufacture or disposal of the drugs a misdemeanor carrying maximum penalties ranging from imprisonment of one year and a fine of $1,000 to imprisonment of 15 years and a fine of $20,000. Leniency is authorized for first offenders.

Johnson praised the law as a measure that will "strengthen the hands of our police and give our families protection." He said it should "put the drug peddler in jail." But, he added, the active support of all Americans—both adults and young—is needed.

* * *

Richard M. Nixon will take over as President pledged to oppose national compulsory health insurance and federal control of physicians' fees. Highlights of his position on health care issues include:

Federal Role in Medicine

The role of the federal government in medicine should be supportive, never dominating. It should serve as a catalyst and supplement private efforts only as needed.

Medicare

Although the program has been plagued by financial and administrative problems, it offers good potential if wisely administered.

Medicare must provide needed services at the lowest possible cost. The program could be endangered by a continuing escalation of costs.

More effort is needed to reduce dependence on costly hospitalization through better use of extended care facilities and increased use of outpatient care. Also needed is a re-examination of reimbursement formulas and experimentation with financial incentives to assure that the program encourages efficiency at all levels.

Medicaid

I favor the basic philosophy of medicaid—that of helping medical indigents who need aid to meet medical expenses. Unfortunately, the program has fallen short of its expectations. . . .

What is needed is a careful reassessment of medicaid, especially at the local level, with full professional guidance, and emphasis on advice from physicians. There also is a need for simplification of literature and application forms.

National Compulsory Health Insurance

I oppose a national compulsory health insurance program because I do not want to lower the quality of medical care in the United States. Also, new health programs should be geared only to persons in need.

I want to see that every individual who needs medical care is able to get it. But I want it to be good medical care. That's why I want to keep the doctors free from government control as much as possible and oppose extension to a national compulsory health insurance program for everyone.

Compulsory Area-wide Health Planning

I oppose compulsory area-wide health planning. We can't assure communities better health planning just by making such groups compulsory. Area-wide planning should be left to state and local determination.

Federal Control of Physicians' Fees

I oppose federal control of physicians' fees. Our system is an open, competitive market, assuring an individual the prerogative of setting a value on the services he performs. I would be as opposed to infringing on this right by regulation of physicians' fees as I would be to regulating fees charged by the members of any other profession.

Department of Health

As President, I intend to establish a Commission on Government Reorganization to study thoroughly ways of increasing efficiency in government organization as well as making it more responsive to the people.

Mental Health

We must develop new methods of treating the mentally ill. . . .

Tax Deductions for the Aged

The 100% income tax deduction for non-reimbursable drug and medical expenses of those over 65 should be restored.

Preventive Medicine

Preventive medicine is, in my judgment, both an opportunity and a major challenge to medicine.

Automated mass screening programs would seem to have great possibilities even though they are generally still in their infancy and therefore cannot yet be gauged concerning their effectiveness in preventing chronic illness and reducing deaths. Information about these programs is still inadequate to warrant a broad federal program.

Hill-Burton Act

As demand for hospital facilities increases, additional funds under the Hill-Burton Act for construction and modernization of such facilities will be required to supplement state and local efforts.

To assure the most efficient use and distribution of Hill-Burton funds, a proposal for block grants in this area should be considered.

Abortion Laws

Nothing should be done on the federal level. The abortion laws should be considered by each state, and should be acted upon by each state, depending upon the opinion in that state. . . . I do not think that a nationally-imposed law would be one which would be accepted in many parts of the country, and only when a state—a majority of people of the state—reach a conclusion that they want that kind of legislation, as they did in Colorado and as they may in the state of New York, should such a law be passed or considered.



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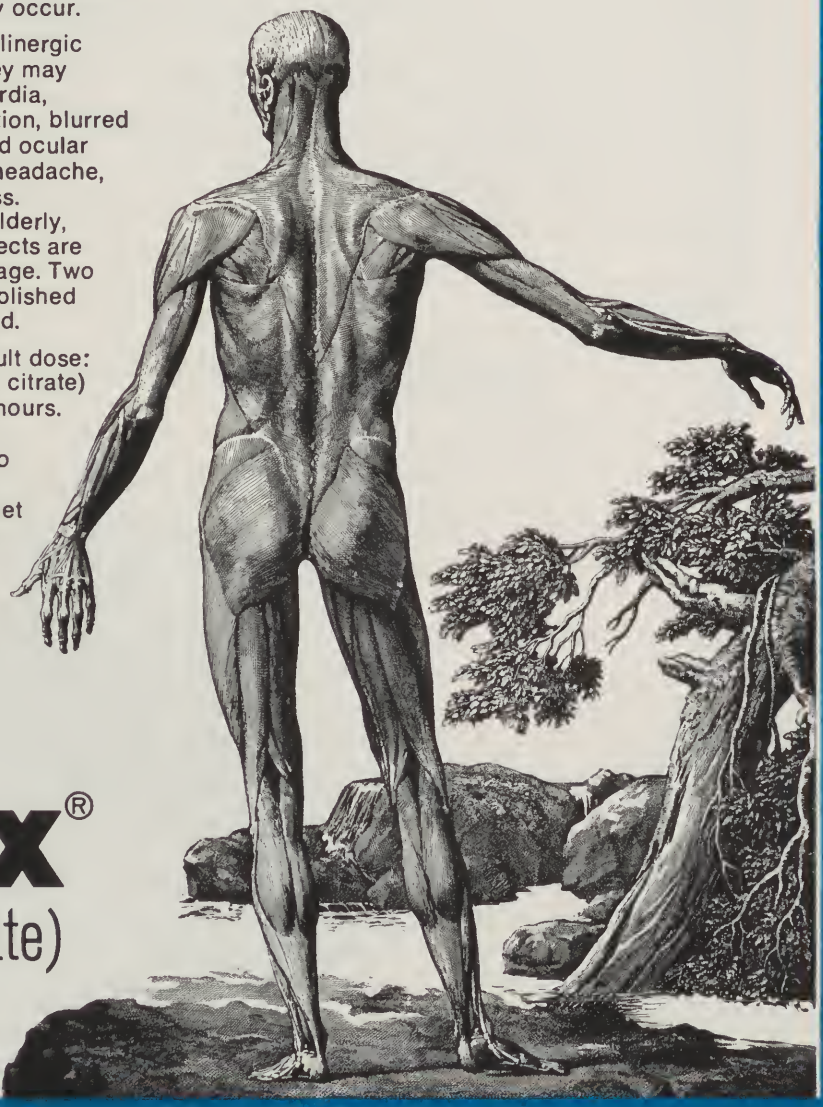
WARNING: Transient lightheadedness or dizziness following NORFLEX-INJECTABLE may occur.

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DOSAGE: **INJECTABLE** — Average adult dose: one ampul, 2 cc. (60 mg. orphenadrine citrate) I.M. or I.V. May be repeated every 12 hours. Relief may be maintained with one NORFLEX tablet b.i.d. **TABLETS** — Two tablets per day for adults, one in the morning, one in the evening. Each tablet contains 100 mg. orphenadrine citrate.

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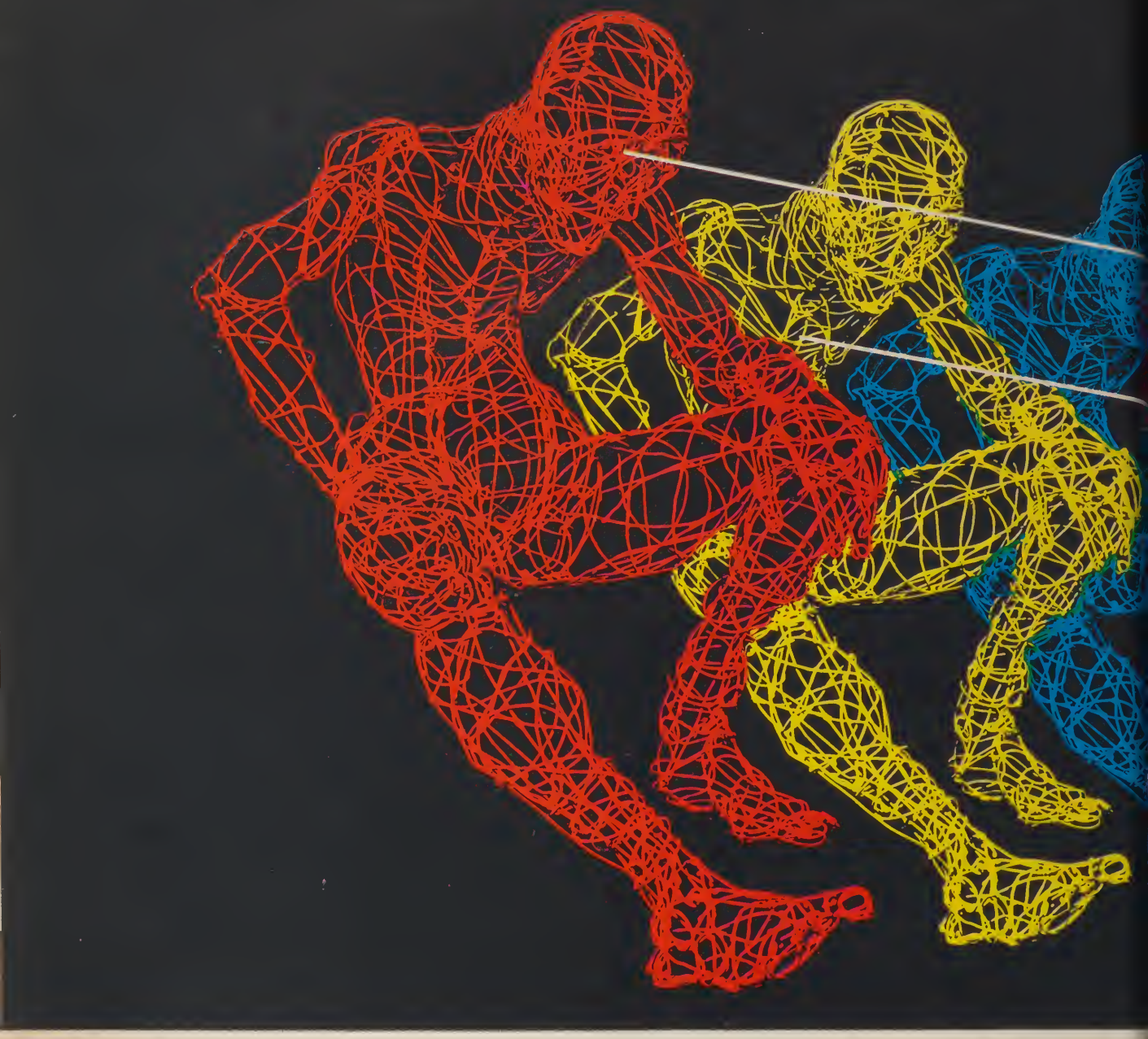
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Folic Acid	1	mg.

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Precautions: Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

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As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potentiation of absorption of physiological doses of vitamin B_{12}. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B_{12}, may be necessary. No single regimen fits all cases, and the status of the patient observed in follow-up is the final criterion for adequacy of therapy. Periodic



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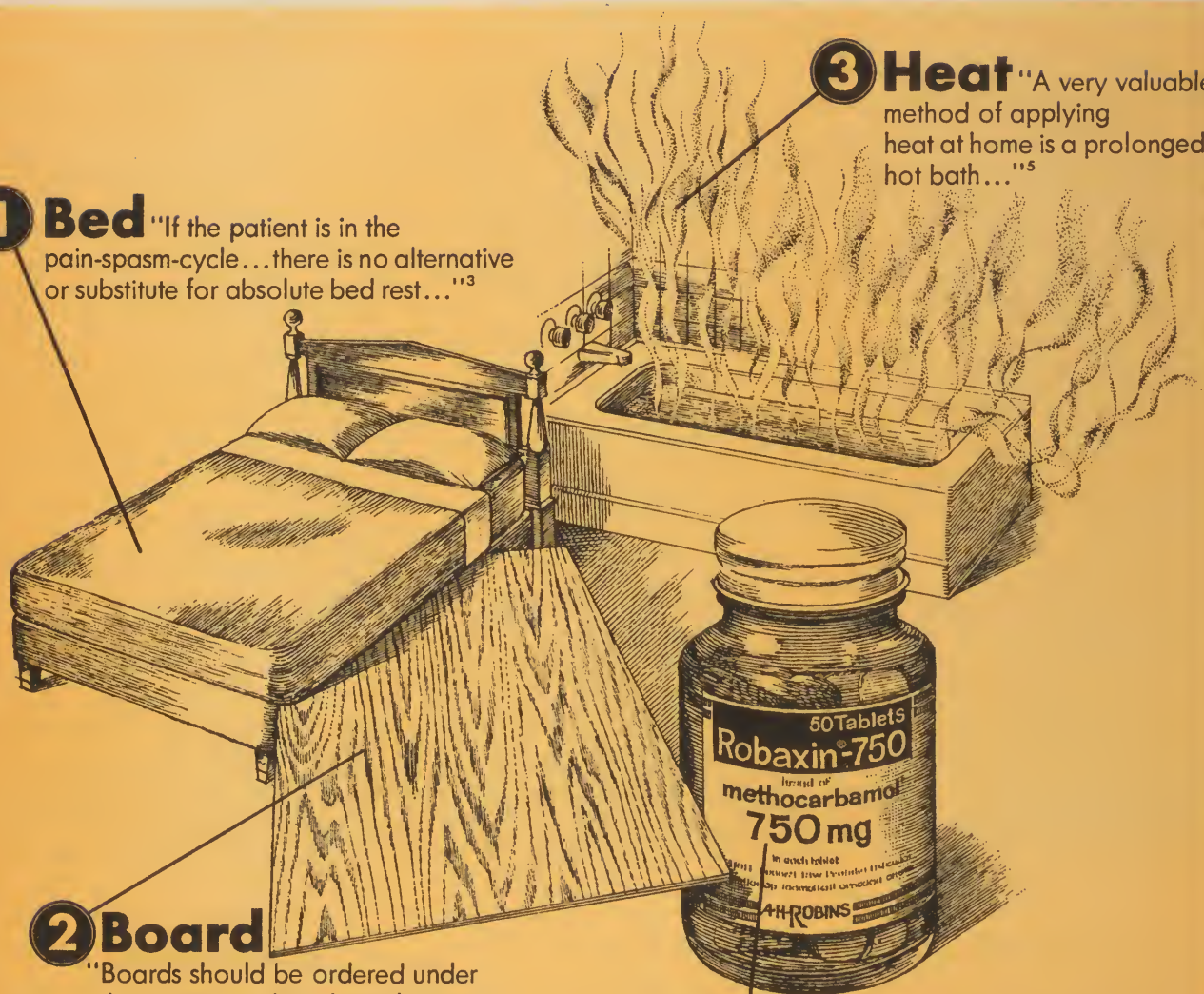
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References: (1). Godfrey, C.M.: Applied Therap. *8*:950, 1966. (2). Gottschalk, L.A.: GP *33*:91, 1966. (3). Rowe, M.L.: J. Occup. Med. *2*:219, 1960. (4). Cozen, L.: South Dakota J. Med. *18*:26, 1965. (5). Soto-Hall, R.: Med. Sc. *14*:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

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171st Annual Meeting

AMONG the many prominent speakers who will present papers during the Annual Meeting in April 1969 are Robert L. Evans, MD, and Howard W. Jones, Jr., MD.

Dr. Jones will speak on diagnostic techniques and procedures in the detection of cervical cancer, which will be of practical value to the general practitioner as well as to the specialist. Dr. Jones, who received much of his education and training in Baltimore, is currently professor of gynecology and obstetrics at The Johns Hopkins University School of Medicine; co-editor-in-chief of Gynecology for *Obstetrical and Gynecological Survey;* and National consultant to the Surgeon General of the U. S. Air Force. Dr. Jones has staff appointments at many local hospitals, and is a member of numerous local, national and foreign medical societies.



Dr. Jones

The Place and Function of a Community Hospital as a Center for Graduate and Continuing Education will be the subject of a paper presented by **Robert L. Evans, MD.** As director of medical education and professional services at York Hospital, Pennsylvania, Dr. Evans directs all professional educational activities, is responsible for the administrative direction of the emergency room, outpatient department, pharmacy, social service, physical therapy, medical records, inhalation therapy, and library. He is also assistant professor of medicine at the University of Maryland School of Medicine. After receiving his MD from Jefferson Medical College, Dr. Evans interned at Jefferson Medical College Hospital and did graduate training for three years at the same institution. He is a diplomate of the American Board of Internal Medicine and the American College of Physicians. Dr. Evans is the author of many publications on undergraduate, graduate and continuing medical education and delivery of health care, and is involved in many professional organizational activities.



Dr. Evans

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April 9, 10, 11, 1969

ANNUAL MEETING—BALTIMORE MEDICAL AND CHIRURGICAL FACULTY

WEDNESDAY, APRIL 9

The Alcazar

9:30 AM Meeting of the House of Delegates
2:00 to 5:00 PM Scientific Sessions

The Sheraton-Belvedere Hotel

6:00 to 7:30 PM Hospitality Night for all members of the Faculty

The Alcazar

8:30 PM Medicolegal Symposium

THURSDAY, APRIL 10

The Alcazar

9:30 AM Scientific Sessions

The Sheraton-Belvedere Hotel

12:30 PM Annual Luncheon

The Alcazar

2:15 PM Scientific Sessions

The Sheraton-Belvedere Hotel

6:15 PM Annual Presidential Reception and Banquet

FRIDAY, APRIL 11

The Alcazar

9:30 AM Scientific Sessions

The Faculty Building (1211 Cathedral Street)

2:00 PM Meeting of the House of Delegates

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MEDICAL NEWS

Russell A. Nelson, MD, president of The Johns Hopkins Hospital, has announced the election of six new members to the Hospital's Board of Trustees. The election fills one vacancy and expands the Board by five to 27 members.

"The expansion," Dr. Nelson said, "reflects the continuing growth of the Hospital's responsibilities and scope of operation. It broadens community representation and will help the Hospital to meet its needs in providing health services in Baltimore."

In addition, Dr. Nelson said the new Trustees will help provide a new foundation for improved relationships and for greater coordination among hospitals in the city. Several of the new Trustees, he said, have served or now serve on other hospital boards in Baltimore.

The new Trustees are:

Richard W. Emory, a partner with the law firm of Venable, Baetjer & Howard.

W. Wallace Lanahan, Jr., president and director of Stein Bros. & Boyce, Inc.

Sidney Lansburgh, Jr., president of the American General Corporation and the Raleigh Haberdasher, Inc., Washington.

John M. Nelson, III, president of The Nelson Company, a subsidiary of Schenuit Industries.

Saul M. Perdue, Ph.D., assistant superintendent of the Baltimore city schools.

George L. Russell, Jr., Baltimore city solicitor.

* * *

The Kresge Foundation, of Detroit, has awarded $250,000 to **The Johns Hopkins Hospital** toward the construction of a $2 million Comprehensive Care Center for Children.

The Center will be constructed on the south side of Monument Street as an addition to The Johns Hopkins Children's Medical and Surgical Center, which opened in 1964.

Robert E. Cooke, MD, pediatrician-in-chief of the Hospital, said that in addition to its facilities for providing comprehensive care to indigent patients, the new Center will house a children's trauma unit and an emergency area for the care of severe non-accidental illnesses.

Dr. Cooke anticipates that the new Center will enable all eligible children to be brought into the comprehensive care program.

Comprehensive care, Dr. Cooke said, includes preventive medicine, including psychological and psychiatric care, as well as care of disease. It extends as far as social rehabilitation and even into community recreation. Health education, including family planning, nutrition, and research into new approaches to child care also are parts of comprehensive care.

The building also will be designed to permit—for the first time—consideration of the problems of efficiency and acceptability of care.

Dr. Cooke said that if consistent, comprehensive care is to be rendered, the patients and their families must find the environment, in which the care is given, acceptable.

In order to test an increase in the effectiveness and efficiency of care, while maintaining acceptability, two comprehensive care "modules" are being developed with participation of community advisors and parents.

After completion of the building, a two-year study will be made to determine which module is most efficient and acceptable.

The Kresge Foundation will support one of the modules; the other will be built with matching funds.

* * *

The Johns Hopkins School of Medicine was one of ten medical schools named to receive grants of $100,000 each year for the next five years from the Richard King Mellon charitable trusts.

According to the *Journal of the American Medical Association* there are 1,374 vacancies today in the faculties of the nation's medical schools —the highest number on record.

"The trustees hope that the grants will enable the schools to maintain and improve the quality of their faculties, and that at the end of the 5-year period, more Federal and other private funds will be available for that purpose," the trustees said.

* * *

A new program to train leaders in the expanding field of community dentistry has been inaugurated on a joint basis by The Johns Hopkins University School of Hygiene and Public Health and the University of Maryland School of Dentistry.

Established in response to a growing national need for dentists with public health training, the program will offer both masters and doctoral degrees.

John C. Hume, MD, dean of the School of Hygiene and Public Health, said the program's aim is to prepare "a limited number of exceptionally qualified candidates for top-level positions in state dental health department programs, community health agencies, universities, and other key institutions."

Burton R. Pollack, DDS, MPH, head of the School of Dentistry's department of community dentistry, who also holds an appointment in the School of Hygiene and Public Health's department of public health administration, will head the new cooperative venture.

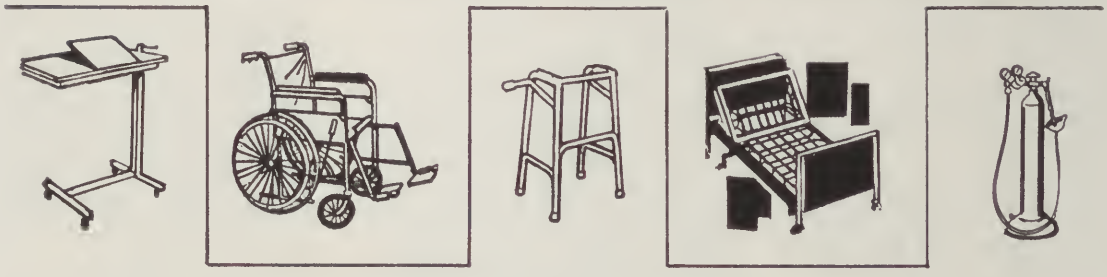
By combining the outreach of The Johns Hopkins School of Hygiene and Public Health with the resources of the School of Dentistry's Community Dentistry Department, Dr. Pollack feels both institutions can have a much greater effect on comprehensive programming for dental health services across the nation.

Dentists enrolled in the program will complete the courses in biostatistics and epidemiology required of all Hopkins Master of Public Health degree candidates. Additional courses in pathology, public health administration, biostatistics, epidemiology, maternal and child health, medical care and hospitals, radiological science, behavioral sciences, and mental hygiene will also be offered, along with several special courses in dental public health administration and oral epidemiology.

Field work and research will be undertaken at the clinic of the School of Dentistry; the School of Hygiene's Epidemiology Training Center for Public Health Research in Washington County, Maryland; the Maryland State and Baltimore City Health Departments; and other activities of The Johns Hopkins Medical Institutions and the University of Maryland.

John Salley, DDS, PhD, dean of the School of Dentistry, pointed out that the new program is a significant example of inter-institutional cooperation in response to community needs.

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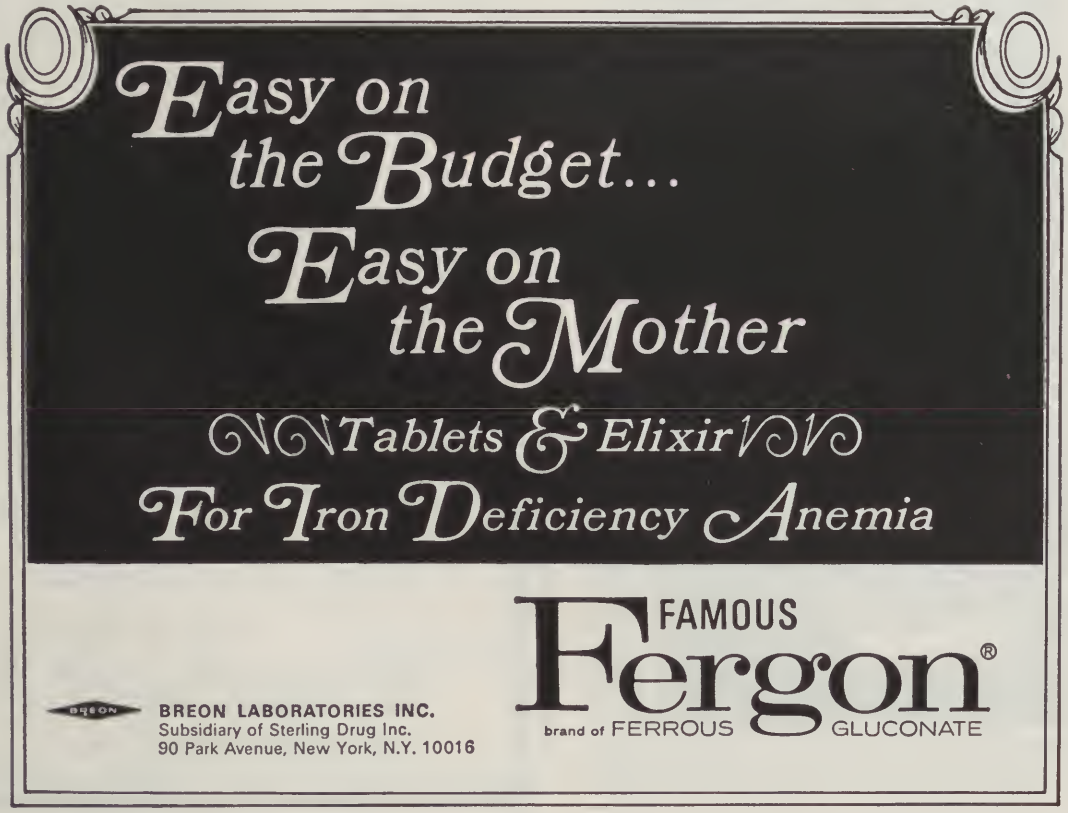
Grants for Environment Studies

How man can prevent crises in his environment instead of constantly being surprised and overtaken by them will be the subject of a variety of research and educational projects for which grants have been announced by the Ford Foundation.

Totaling nearly $4 million, the grants will finance such activities as research on the effects of overcrowding on human physical, social, and psychological makeup, a case study of the potential impact of weather modification proposals on grassland vegetation, and the use of computers to study activities ranging from the management of fish to population pressures on urban transportation.

The Johns Hopkins University will receive $858,000 for a new graduate program in geography and environmental management. The University will use the Foundation's grant to add three social scientists, a visiting professorship, and seven graduate fellowships to its Department of Geography and Environmental Management, which was recently formed through the merger of its Departments of Civil Engineering and Geography. These departments have long had strong interests in water supply, pollution, and other urban problems, and the objective of the merger is to broaden the insights and competence of both professional geographers and sanitary and civil engineers.

The additional staff, which will include a resource economist, a cultural geographer, and an anthropologist, will enable the university to establish a new graduate program in environmental management focused on contemporary problems.





Book Reviews

ORR'S OPERATIONS OF GENERAL SURGERY, By George A. Higgins, MD, FACS; W. B. Saunders Co., Philadelphia, Pa. 1968.

This fourth edition updates previous editions and serves both the beginner in surgery and the general surgeon as well. The author states, ". . . that such a volume as this still serves a useful purpose in the training and practice of those who are to assume responsibility for the future of surgery." It contains descriptions of basic surgical techniques and common operative procedures as well as specialty surgery by means of concise narrative description and a few well executed illustrations.

An effort has been made to point out dangers inherent in various operations and to outline safeguards by which these pitfalls can be avoided.

ATLAS OF EAR SURGERY by William H. Saunders, MD; and Michael M. Paparella, MD; The C. V. Mosby Company, St. Louis, Mo. 1968.

This volume is intended to serve as an illustrated guide for residents and graduates in otolaryngology who may want a reference book on the techniques of otologic surgery. It is also a convenient reference for other physicians interested in the current status of otologic surgery.

Emphasis is placed on surgery of the external and middle ear and surgical treatment of Meniere's disease.

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SYNOPSIS OF PATHOLOGY, by W. A. D. Anderson, MD, and Thomas Scotti, MD; The C. V. Mosby Company, St. Louis, Mo. 1968.

This is the seventh edition of this book and represents the new knowledge and concepts in the diverse fields of cytology, cytochemistry, microbiology, genetics and immunology, as well as clinical observation and practice.

All chapters have been revised and brought up to date, and some new chapters have been added to the volume.

This book will continue to be useful to students of general and systemic pathology; to clinicians who must maintain familiarity with the foundation sciences of medical practice, and to others in medical and paramedical fields who need to keep abreast of current developments of disease processes.

SURGERY OF THE ADRENAL GLANDS, by Lawrence W. O'Neal, MD; The C. V. Mosby Company, St. Louis, Mo. 1968.

Today, when more is known about the adrenal gland than one intellect can easily encompass, the sheer volume of available information and its complexity are somewhat intimidating to the clinician. Successful involvement in the care of patients with surgical diseases of the adrenal gland requires more than a knowledge of anatomy and technique.

This volume provides that knowledge, which is enhanced by the special sections dealing with steroid physiology, radiology, anesthesia, adrenomedullary and nerve tumors in children. It is intended primarily for use by physicians.

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JANUARY 10, 1969—12:30 P.M.

THE BLEEDING PATIENT

Philip D. Zieve, MD

Assistant Professor of Medicine
The Johns Hopkins University School of Medicine, and
Assistant Chief of Medicine,
Baltimore City Hospitals

The important features of the history and physical examination of a patient with an apparent hemorrhagic diathesis will be discussed. The various tests performed in the laboratory to establish a precise diagnosis in such a patient will be described. Appropriate therapy will be outlined.

Sponsor: Prince George's General Hospital

Replays: Monday, January 13, 1969 12:30 P.M.
Wednesday, January 15, 1969
9:00 A.M., 2:00 P.M., 8:00 P.M.

JANUARY 17, 1969—12:30 P.M.

ERYTHROBLASTOSIS FETALIS

Julius R. Krevans, MD

Associate Professor of Medicine
The Johns Hopkins University School of Medicine, and
Chief of Medicine,
Baltimore City Hospitals

The ultimate goal of medicine is prevention of disease. The most common cause of erythroblastosis can now be considered a candidate for eradication. This talk will include a discussion of the cause of erythroblastosis fetalis and of the experiments performed by a number of groups in recent years to prevent the occurrence of the disease.

Sponsor: Harford Memorial Hospital

Replays: Monday, January 20, 1969 12:30 P.M.
Wednesday, January 22, 1969
9:00 A.M., 2:00 P.M., 8:00 P.M.

JANUARY 24, 1969—12:30 P.M.

CYTOLOGY IN THE DIAGNOSIS AND TREATMENT OF CANCER

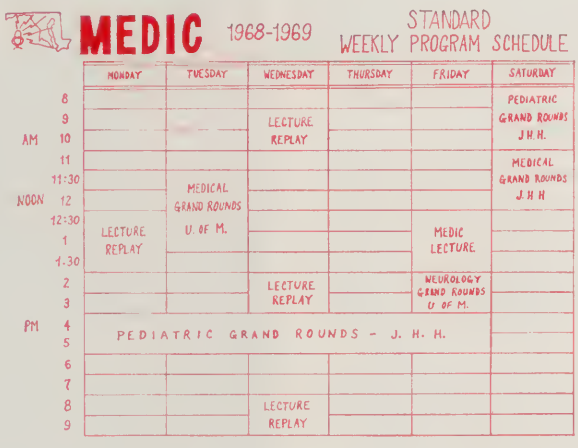
John K. Frost, MD

Associate Professor of Pathology
The Johns Hopkins University School of Medicine

A critical evaluation of the value of clinical cytopathology in the practice of medicine. This discussion will involve mainly the genitourinary, gastrointestinal, and respiratory systems, with a survey of the clinical procedures for obtaining specimens, interpretation of results, pitfalls to be avoided, and obtainable clinical assistance.

Sponsor: Frederick Memorial Hospital

Replays: Monday, January 27, 1969 12:30 P.M.
Wednesday, January 29, 1969
9:00 A.M., 2:00 P.M., 8:00 P.M.



Participating hospitals:

Anne Arundel General, Annapolis
Baltimore City, Baltimore
Baltimore County General, Randallstown
Bon Secours, Baltimore
Calvert County, Prince Frederick
Carroll County General, Westminster
Church Home, Baltimore
Cumberland Memorial, Cumberland
Easton Memorial, Easton
Eugene Leland Memorial, Riverdale
Franklin Square, Baltimore
Frederick Memorial, Frederick
Greater Baltimore Medical Center, Towson
Harford Memorial, Havre de Grace
The Johns Hopkins, Baltimore
Kent & Queen Anne's, Chestertown
Keswick, Baltimore
Lutheran, Baltimore
Maryland General, Baltimore
Mercy, Baltimore
Montgomery General, Olney
North Charles General, Baltimore
Peninsula General, Salisbury
Prince George's General, Cheverly
Provident, Baltimore
Rosewood State, Owings Mills
Sacred Heart, Cumberland
St. Agnes, Baltimore
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St. Mary's, Leonardtown
Sinai, Baltimore
South Baltimore General, Baltimore
Union Hospital of Cecil County, Elkton
Union Memorial, Baltimore
University of Maryland, Baltimore
Washington County, Hagerstown

Other Locations:

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State Office Building, Baltimore
Hospital Council of Maryland, Inc., Baltimore

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1211 Cathedral Street, Baltimore, Maryland 21201
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Summation:
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Precautions: Administer with caution in the presence of incipient glaucoma.

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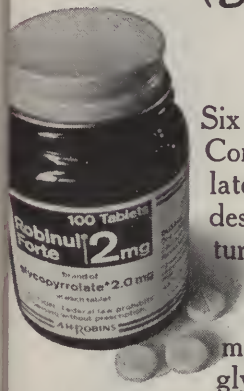
Dosage: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day; in the a.m., early p.m., and at bedtime. See product literature for full prescribing information.

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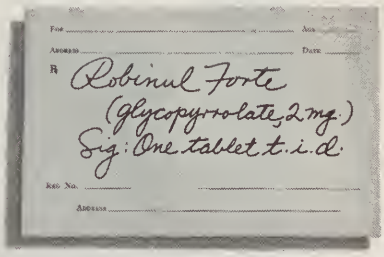
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Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

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Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

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The Maryland Association of Medical Assistants

Dr. Salvador Rossello Speaks to Baltimore Association

On October 8, 1968, at the regular monthly meeting of the Baltimore Association of Medical Assistants, Salvador Rossello, MD, presented a discussion on "Aspects of Gynecology." Although Dr. Rossello centered his talk mainly on birth control pills, hormone maintenance, and douching; many other interesting gynecological matters were brought up for discussion.

The members learned the importance of maintaining an adequate hormone level in women during and after menopause, and the type of medications available to produce satisfactory effects. Dr. Rossello also discussed many concepts of birth control pills, including the much distorted evaluation of "the pill" as brought about by the news media. On the subject of birth control pills, Dr. Rossello presented very impressive statistics in favor of using such a method of contraception.

Dr. Salvador Rossello was graduated from New York Medical College in 1946. He served his internship at the Medical School of Jersey City, New Jersey.

After serving for six years in obstetrics and gynecology with the United States Army, he completed his residency at Lutheran Hospital in Baltimore.

Dr. Rossello is presently in private practice in Baltimore.

Christmas Packages Sent to Viet Nam

The Maryland Association of Medical Assistants has again successfully completed its goal for the 1968 Viet Nam Christmas project. Members of the Baltimore, Alleghany-Garrett, Wicomoco, and Montgomery chapters supplied items needed to fill Christmas stockings to be sent to the servicemen in Viet Nam.

Mrs. Barbara Daniel, chairman of the project, contacted Chaplain Richard McLean of the Headquarters 27th Engineering Batallion Combat Division to assist in insuring transportation of the packages in time for Christmas. The packages will be distributed to men who have no families, and would not otherwise receive any Christmas presents.

The Baltimore chapter received money donations from numerous generous people and were able to purchase items which were not donated. Most gratefully appreciated was a donation of one hundred dollars from William Lumpkin, MD.

Included in the packages were such items as games, fruitcakes, shaving aids, pens, canned fruit and tuna fish, and books. Clothing and other necessities were also sent for the Chaplain to distribute to the orphans and refugees of the area.

The committee had a packing party on October 22, 1968, and the packages were prepared for the trip to Viet Nam. Members assisting in packaging were: Barbara Daniel, Dorothy Hartel, Elva Edmonston, Nell Chaney, Peggy Bury, Eleanor Mainhardt and Estelle Bean.

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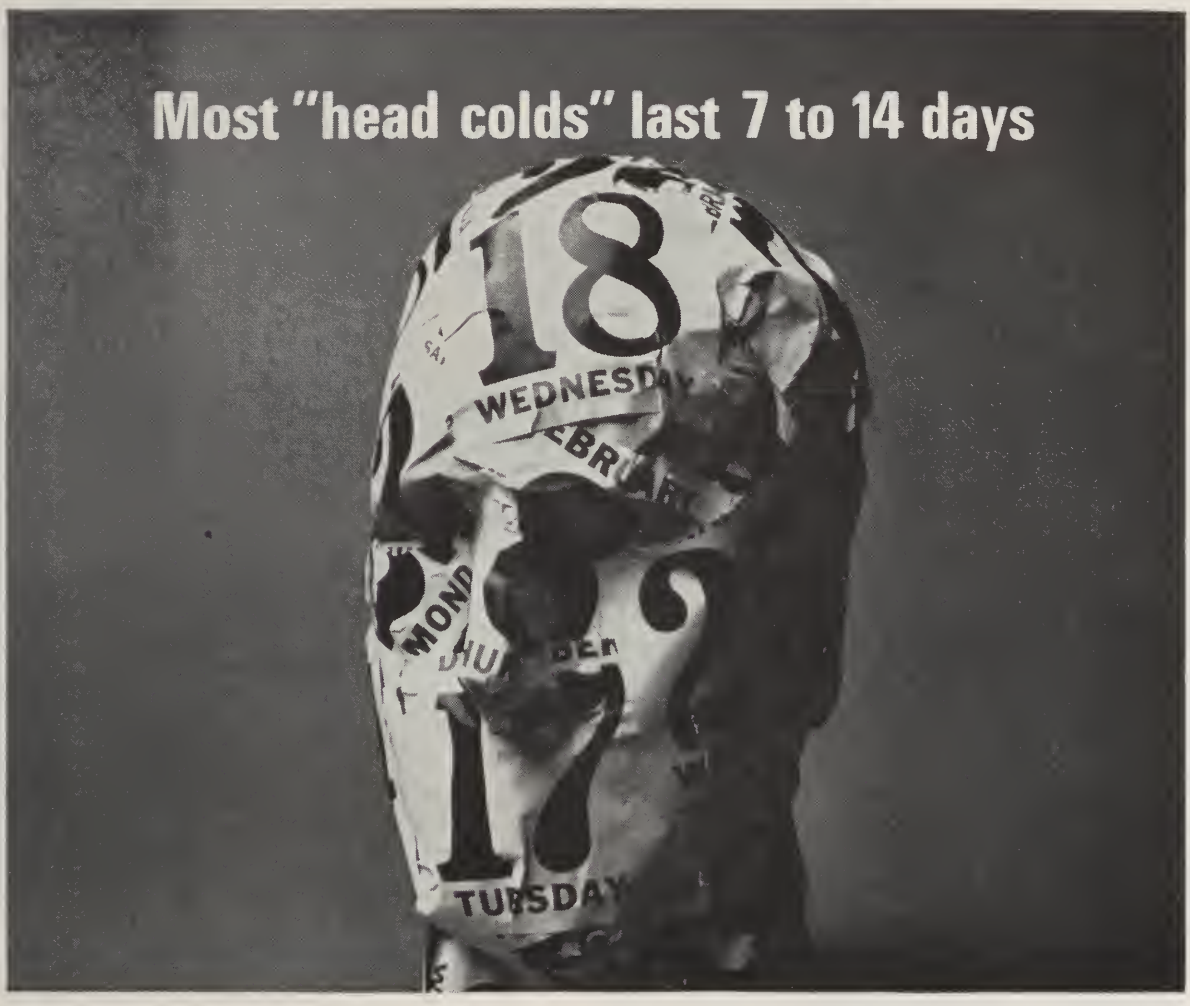
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Usage in Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.
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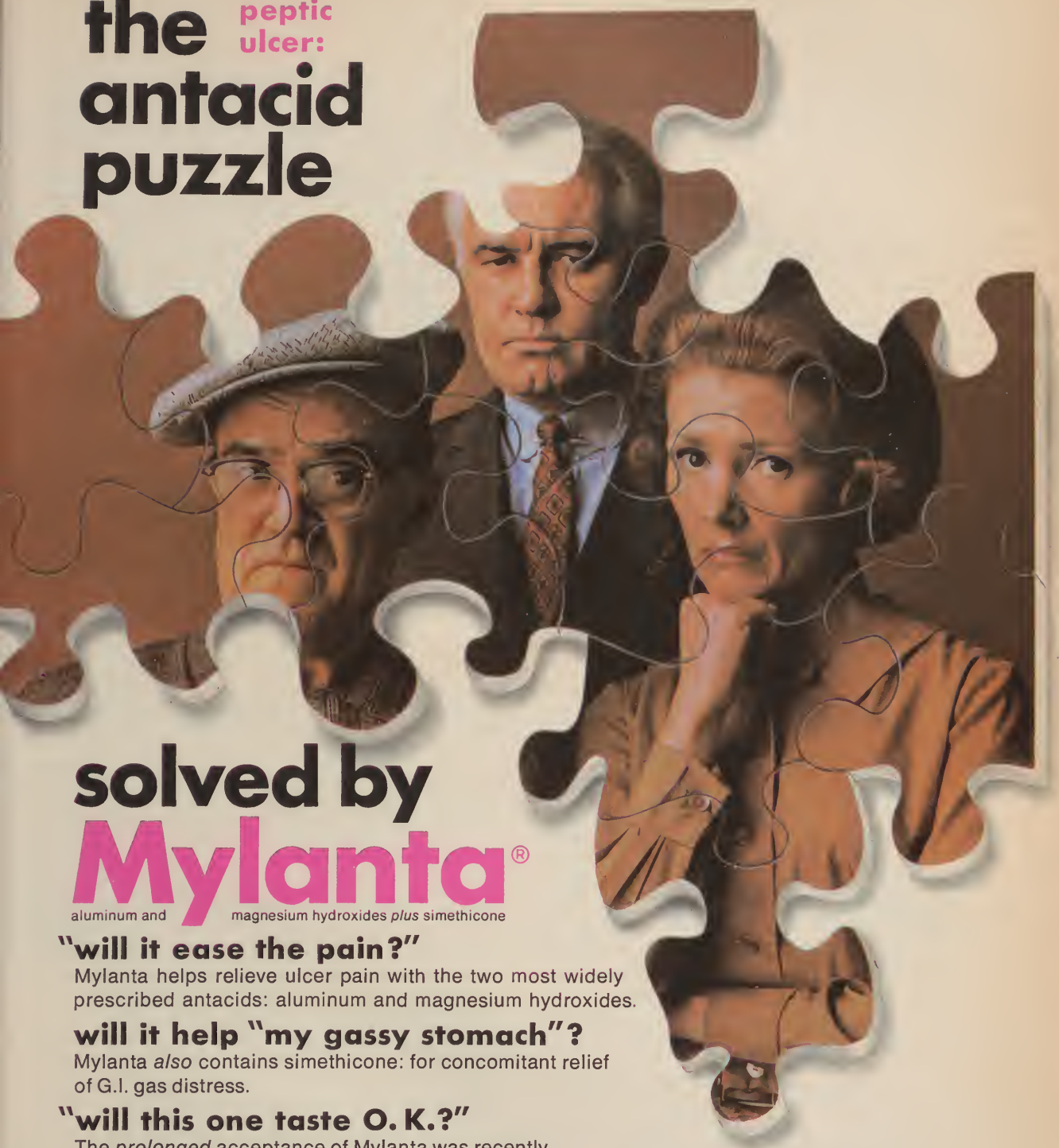
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Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart

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Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

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A total daily dosage of 3 or 4 tablets will normally provide the continuous relief your patient expects. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

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On the next page is a summary of adverse reactions, contraindications, warning and precautions.

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For brief summary see next page.

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Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

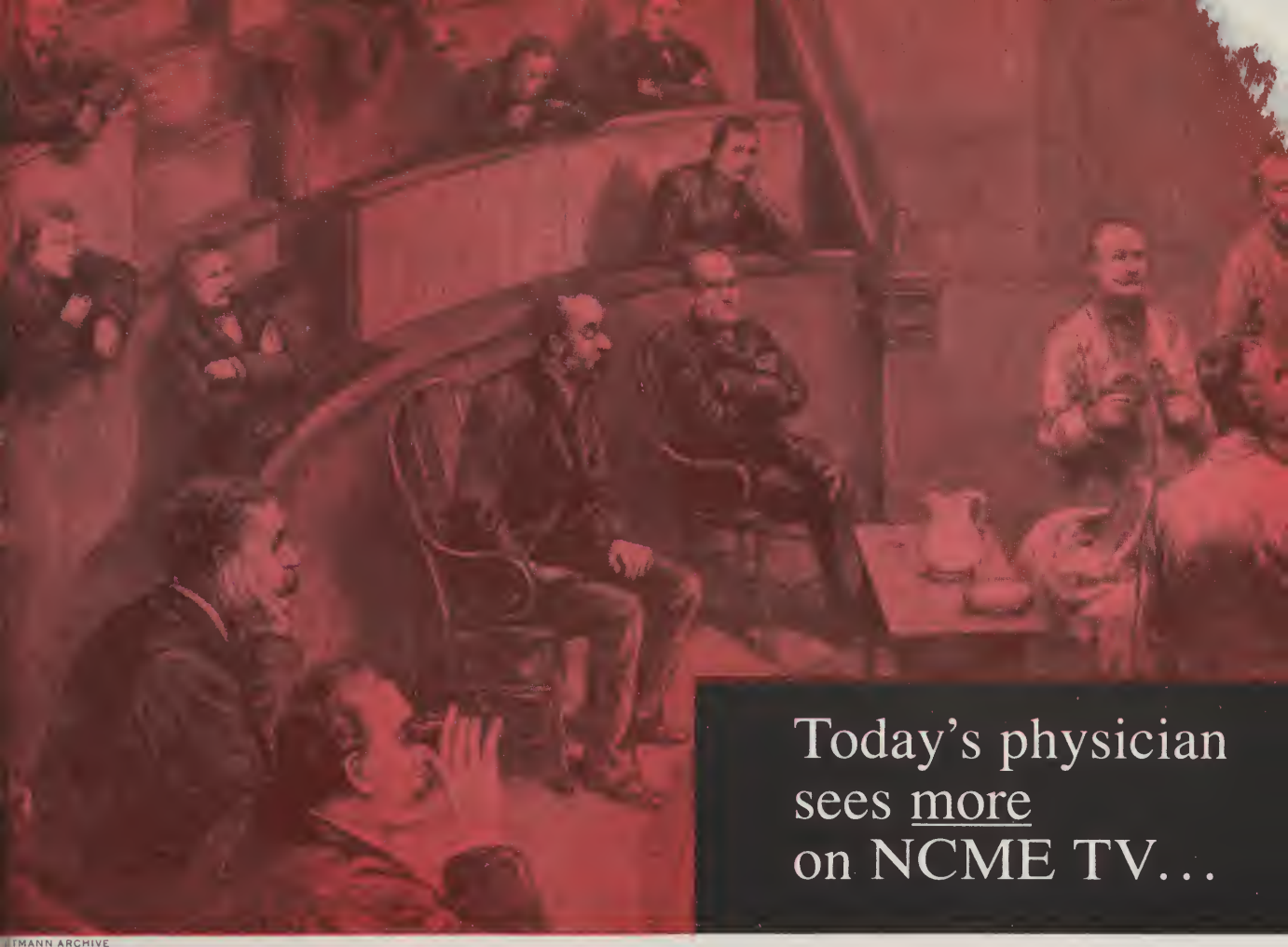
In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

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The **Maryland State Medical Journal** is about to embark upon its 18th year of continuous publication as the official sounding board of the membership of the Medical and Chirurgical Faculty of the State of Maryland. The question now is not that of whether or not we should keep printing a monthly publication, but one of how we can make the Journal more effective as a vehicle for the free exchange of information and ideas?

To quote George H. Yeager, MD, the first editor of the revitalized Journal, "The advent of this publication (January, 1952) represents the culmination of the hopes and efforts of the officer body of the Faculty. . . . Circulation figures do not of necessity indicate reader interest. If our State Journal is read throughout, a worthwhile service will have been rendered. . . . We are fully persuaded that the best interests of the Faculty demand some means of binding individual members more closely to the organization. It is imperative that the work of the State Society, as well as that of the American Medical Association, be kept before its members."

During its 17 years, the Journal has been expanded to include the interests of various factions and societies around the State; special issues have been presented, and the format has been revised constantly. Our circulation is still limited to the membership and a few special subscriptions and this we do not expect to change.

The quality of the articles submitted to the Journal for publication has been exceptional—without the participation of the membership there would be no Journal. But, our main problem still lies in readership of the publication. We do not expect it to be 100%, but it has been an appalling experience for members of the Journal staff to be confronted with suggestions from Maryland physicians that we should revise the cover, devise new headings for the department pages, etc. In June of this year, the Journal underwent a drastic "face-lifting". We have gone one step further in sending the Journals under labels rather than in envelopes. If you were sufficiently startled by the October cover into reading the Journal for the first time, then we have accomplished something. We would appreciate it if you would offer us your critical evaluation of the publication—we are constantly seeking new ideas on all facets—and if you would bring the Journal to the attention of your non-Journal-reading colleagues.

We feel that once we have piqued the interest of the members we will be in an even better position to achieve the aims of the Journal as set forth by Dr. Yeager and acclaimed by C. Thomas Flotte, MD, the present editor. If we do not gain a wider readership through our efforts and yours then the process of evolution of the Journal is merely revolution—misguided, misdirected and virtually unnoticed.

This is your Journal. We are doing what we can with it, the rest is up to you. Again to quote Dr. Yeager, "Utilize the Journal to further enhance the purposes of this Society. Thereby, it can serve as a physical access and overcome some of the previous geographical limitations of this Society."

JUDY SOWELL
Managing Editor

THE MEDICAL EXAMINER SYSTEM IN MARYLAND—An Ideal System

Prior to the creation of the Office of Chief Medical Examiner by the Post Mortem Examiner's Law, there existed in Maryland The Office of Coroner, an offshoot of the colonial Sheriff's Office. In forming their government, Maryland colonists drew upon their knowledge of the English sheriff and coroner.

EDWARD F. WILSON, MD
Assistant Medical Examiner, State of Maryland; Instructor in Pathology, University of Maryland School of Medicine

RUSSELL S. FISHER, MD
Chief Medical Examiner, State of Maryland; Professor of Forensic Pathology, University of Maryland School of Medicine

The Coroner in England

The Coroner's Office was first mentioned in the "Charts of Privileges", granted by King Athelstane to St. John of Beverly in the year 925.[1] The Office of Coroner was established in September 1194, when the justices in eyre* were required to see that three knights and one clerk were elected in every county as keepers of the pleas of the crown.

The coroners had to be selected from among those of sufficient estate for two reasons: ● to support themselves in office which was unpaid and which lent itself to extortion and oppression and, ● to guarantee that they were distrainable* and able to pay financial penalties incurred to the king or damages inflicted upon his people.

The coroner could be ordered to perform almost any duty of an administrative or inquisitorial nature within his domain, either alone or with the sheriff, but there were other duties which belonged more specifically to the Coroner's Office and which he performed without being ordered to do so. These consisted of holding inquests upon dead bodies, legalizing and recording abjurations* of the realm made by felons in sanctuary, appeals,* confessions of felons, appeals of approvers,* exactions,* and outlawries* made public during the county court.

These were the crown pleas which the coroner had to keep and he kept them in four ways: by taking the actions just mentioned; attaching or arresting witnesses, suspects, and others; appraising and safeguarding any lands and goods which might later be forfeited, and by recording all the details.[2]

These duties were not new in 1194; they, or many of them, had previously been performed by other local officials, notably by the county justiciar and by the sergeant or by the bailiff of the hundred, a division of the county. Under Henry I, 1100-35, and Stephen, 1135-54, every county had its justiciar, who had some of the duties which later belonged to the coroner, especially those concerning forfeitures to the crown. The county justiciar not only kept the crown pleas but he also determined

* *See Glossary on page 53.*

them. He naturally tended to grow overpowerful, and Henry II, 1154-89, discontinued the office early in his reign. Thereafter, the hundred and wapentake sergeant held inquests upon dead bodies, and heard appeals in their early stages and confessions, and almost certainly received abjurations of the realm and heard appeals of approvers as well—duties which they well may have performed under the justiciars earlier.[2]

Because of his perennial continental wars and the need to pay his ransom, Richard I, Coeur de Lion, 1189-99, was desperate for money and could not afford to lose any of the financial issues of crown pleas. This meant that a full time local official was needed to minister to the recently organized general eyre. Neither the sheriff nor his subordinates could adequately accomplish this task. The sheriff was already overburdened and his tendency to become overpowerful and corrupt was strong. In the closely integrated interests of good order, justice, and royal revenue a new local official was established. Administrative efficiency was served by relieving the sheriff of some of his burdens; and judicial efficiency and royal revenue benefited from having an official who could concentrate mainly upon preserving full details of crown pleas between eyres and who, being elected and of some social eminence locally, could be expected to reduce, if not prevent, misappropriation of money by the sheriff, at least in crown pleas.[2]

The only instruction issued in 1194 seems to have been that the coroners should keep the pleas of the crown. An important result of the failure to define the coroner's duties in and shortly after 1194 was that an immense gap soon appeared between the theoretical implications of his formal title, Keeper of the Pleas of the Crown, and the few pleas with which he came to be concerned by virtue of his office. Not only was the coroner never concerned ex-officio with crown pleas other than felonies and unnatural deaths, but homicide and suicide were the only felonies with which he was invariably concerned. Other felonies only entered his sphere when they resulted in homicides, abjurations, appeals, confessions, or exactions, or if he were specially commissioned to inquire about them. This development was a result of the close link of the coroner with the general eyre, and in the probable absence of any authoritative list of crown pleas, his guide must have been the presentments made to the general eyre.[2]

By Edward I's reign, 1272-1307, all coroners' cases were presented in answer to one article (the second) of the eyre. As to the office and power of the coroner as ascertained by the statute of Edward I, Blackstone said, **"The office and power of a Coroner are also like those of a Sheriff, either judicial or ministerial, but principally judicial. . . . And consists, first, in inquiring, when any person is slain or dies suddenly, or in prison, concerning the manner of his death. And this must be upon sight of the body; for if the body be not found, the coroner cannot sit. He must also sit at the very place where death happened, and the inquiry must be made by a jury from 4, 5, or 6 of the neighboring towns over which he is to preside. If any be found guilty by this inquest of murder or other homicide, the coroner is to commit them to prison for further trial and must certify the whole of this inquisition, together with the evidence thereon, to the Court of King's Bench, or the next assizes."**[3] So it was that the coroner's inquest became and remained confined to cases of death, although in a few exceptional areas coroners had dealings with other felonies.

The Sheriff in England

The sheriff in the vast majority of English counties was appointed by the King from a list of three persons provided by the Exchequer. The appointments as sheriff were confined to those having sufficient estate. This qualification was intended to guarantee the responsibility of the sheriff, but other financial requirements of the office—the heavy expenses entailed at his entry into office, in entertaining the judges and county gentry at the assizes, and the process of accounting into the Exchequer—likewise necessitated the sheriff's being a member of the wealthy class in the county.[4]

The sheriff was the chief executive official of the county court. He appointed the officials of the court—the undersheriff, the county clerk, and the bailiff—all except the coroners, who were elected by the freeholders there assembled.[4]

On command of the justices of the peace the sheriff notified the county of the place and date of the next court session. He notified various officials to be present with their records of office.

The sheriff summoned prospective jurors and impanelled and swore all juries. He carried out orders to arrest, to imprison, to set at liberty, to produce in court or to take good security to appear in court, and to hang those found guilty of

felony. The sheriff could call to his aid all the able-bodied men in the county—the posse.

From the earliest date the sheriff had been the King's bailiff to conserve and collect the royal rights and revenues in the county. The traditional revenues of the King, which he possessed independently of Parliament, were derived from feudal rights, rents, fines, forfeitures of the goods of felons and outlaws, deodands,* wreck of the sea, waifs, estrays, treasure trove, the killing of whales and wild swan, and from various other sources.[4]

All royal officials in the county assisted in the collections of the extra-parliamentary revenue, but the chief responsibility was relegated to the sheriff and justices of the peace. The collections of extra-parliamentary revenue by the sheriff were, during the period 1603-40, greatly increased through the efforts of James I and Charles I to become financially independent of Parliament. In fact the sheriff's most responsible duty during that period was as collector and receiver for the King of the extra-parliamentary revenue in each county.[4]

The Sheriff in Maryland

On June 20, 1632, Charles I of England granted the Maryland Charter to Cecilius Calvert, Baron of Baltimore, the son of Sir George Calvert, First Lord of Baltimore. While the charter virtually gave a royal jurisdiction to the Baltimores, it also laid the foundation of popular government in the colony by providing that the Proprietor make the laws with the advice and assent of the freemen or their deputies. Cecilius Calvert did not go in person to Maryland, but commissioned his brother Leonard Calvert as governor, delegating to him complete executive, legislative, and judicial authority in the colony.

The colonists left England on November 27, 1633 aboard the *Ark* and the *Dove* and on February 27, 1634 landed at the mouth of the Potomac and began a settlement which they named St. Mary's.

The first settlers in the colony possessed considerable knowledge of English government, but no attempt was made to transplant English judiciary. Pioneer life demanded for the busy inhabitants a quick and certain justice through procedures that could be understood by the average person.

St. Mary's County at first included all the settlements. At a very early date it was put under the civil and military control of a commander who with the assistance of a commissioner of the peace, constituted the government.[4]

A privilege of the colonial governor incident to the charter was that of appointing the sheriff.

On January 29, 1637, the Governor, Leonard Calvert, appointed Thomas Baldridge of St. Mary's to be Sheriff and Coroner and authorized him to "**Doe all and everything . . . the office of sheriff and coroner of any county in England doe . . .**"[5] Until 1666 the Office of Coroner remained combined with the Office of Sheriff.

The first recorded case of the coroner's jury in Maryland took place on January 31, 1637. This was an inquest before the coroner in St. Mary's County over the body of John Bryant. There were

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* GLOSSARY

Abjuration—After confessing a felony, the abjuror swore on the Gospel to leave the realm of England and never return except with the King's permission.

Appeal—To accuse; for example, the appellor accused the appellee. The coroner viewed the appellor's wounds, recorded the appeal, and if the wounds appeared likely to be fatal, arrested the appellee.

Approver—The King's witness.

Deodand—An animal or article which having been the immediate occasion of death of a human being, was forfeited to the crown to be applied to pious uses.

Distrain—To coerce or punish by levying a distress.

Exaction—Public demand that the appellee (defendant) appear and surrender to justice.

Eyre—Judges, who under temporary royal commission, rode circuit to hold the courts in the different counties in England.

Outlawry—If the appellee still absented himself on the fourth exaction he was outlawed. An outlaw's goods and chattels were forfeited to the King and his head could be cut off with impunity by anyone. Under Richard I a price was paid for an outlaw's head.

12 jurors, all men. The verdict was that **"John Bryant by the fall of a tree had his bloud bulke broken; and hath two scratches under his chinne on the left side; and so that by means of the fall of the said tree upon him the said John Bryant came to his death."**[6]

The colonial office, in contrast to the sheriff's office in England was much sought after because it always assured its occupants a substantial income, even though the office usually carried no salary. The sheriff was responsible for the collection of the property tax, poll tax, and various other levys, and he usually received 10% of his collections.[4] Thus Maryland's Sheriff's Office was one of profit and power.

The assembly that met in March 1638/1639 passed "An Act for the Appointment of Certain Offices." This provided that any inhabitant, not a member of the council, might be appointed sheriff and coroner of a county by the Chief Judge, who was the governor. Like other acts passed at this session, this act failed to become law because of a disagreement between the governor and the assembly as to the method of initiating legislation. However, this procedure for appointing the sheriff was followed as late as November, 1656.

On April 30, 1640 the governor appointed John Robinson, High Constable, as coroner for St. Clements Hundred in St. Mary's County and defined his duties: **"Upon notice or suspicion of any person that hath or shall come to his or her death entirely within the limits of that hundred to warn as many inhabitants of the said hundred as you conveniently may to view the dead body and to charge the said persons with an oath truly to inquire and true verdict to grant how the person viewed came upon his or her death according to the evidence . . ."**[5]

Under the act of 1642 a sheriff for each county was to be appointed by the Chief Judge of the Provincial Court who was usually the governor, or by the presiding judge of the county court, from persons recommended by a majority of the bench, and his term of office seems to have been at the pleasure of the court.

After the passage of the act of 1661, as amended in 1662, the sheriff was to be selected by the governor from three persons nominated by the county court and his term of office was to be limited to one year.

The Coroner in Maryland

In 1666 an act providing for regular appointment of coroners was passed authorizing the governor, from time to time, to appoint qualified men as coroners in the several counties. A different individual was to be appointed sheriff.[7]

In September 1666, at the Somerset County Court, an announcement was made of the appointment of William Stevens as coroner by the governor under the law of April 1666.

Perhaps the first medicolegal autopsy in Maryland was recorded on March 21, 1665/1666 when Mr. Francis Carpenter was brought to the Talbot County Court on suspicion of murdering his servant, Samuell Yeoungman.

"Wee of the Jury haueing viewed the Corps of Samuell Yeoungman and finding A Depression in the Cranenum in on (one) place, and another wound where all the muscle flesh was Corrupted, and withall finding Corrupt blood betweene the Dura and Piamater, and the brainc and severall other bruises in the head and body therefore our virdict in that for want of Looking after the abouesaid wounds, were the Cause of his death"[8]

The 1671 act defined the duties of the coroner to include holding of inquests over the bodies of those dead by misadventure, murder, suicide, or other forms of violence as well as the serving of writs or subpeonas upon a sheriff in any suit to which he was a party or for the arrest of a sheriff.

In 1860, for the first time, a physician was mentioned in connection with the work of the coroner. In that year the Maryland Code of Public General Laws authorized the coroner or his jury to require the attendance of a physician in cases of violent death. However, the choice of physician was left to the coroner.

In 1868 the law authorized the governor to appoint a physician as the sole coroner of Baltimore city. As the population of Baltimore increased, more coroners were appointed, and in 1939 there were ten physicians serving as coroners. However, it was not until the 1930's that physicians were appointed as coroners in most of the Maryland counties. In fact, some of the counties, up to the change of the law creating the medical examiner system, continued the lay service for the office.

In 1890 a Baltimore city ordinance authorized the City Board of Health to appoint two physicians with the titles of medical examiner and assistant medical examiner, whose duty it was to perform all autopsies requested by the coroners or the state's attorney of Baltimore city. In 1921 the titles were changed to Post Mortem Physician and Assistant.

The procedure followed by the coroner in his investigation of a suspicious death usually followed a definite routine. When notified, either the coroner or his representative would visit the scene. If the coroner decided that the death was not a suspicious one, the investigation ended. On the other hand if he decided the death was suspicious, he held an inquest.

The Coroner's Inquest

The inquest was preceded by the selection of a jury which was taken to the scene of the suspected crime. After the visit to the scene the coroner set up his court over which he presided, with the jury in attendance. At the conclusion of the testimony, the coroner decided the nature of the case by directing a certain verdict by the jury or he allowed the jury to arrive at its own verdict. Since the coroner was a judicial officer, he had the power to order a person or persons to be placed under arrest for the crime charged.

Over the years, the inefficiencies of the coroner system had given the thinking public, lawyers, and physicians concern. It was readily seen and understood that combining law and medicine was not conducive to the best interests of the people or the courts.

As an elected or appointed official, the coroner was particularly vulnerable to political pressures. Pressure was exerted on the coroner to suppress evidence pointing to suicide or he was asked to decide that a certain individual died accidentally when all evidence pointed to natural death. The coroner was asked to put individuals on his payroll regardless of their qualifications. Specifically he was asked to select physicians regardless of their medicolegal qualifications.

In the examination and investigation of sudden death, two questions arise. First, how did death occur? Second, by whom was it caused? The medical profession should be responsible for answering the first question, and the police, law, the courts, the second.[9]

Boston and New York City

The coroner system in Boston was replaced on July 1, 1877 by the first medical examiner system in the United States. However, the medical examiner law was not ideal and contained such deficiencies as authorizing the governor to appoint the medical examiner, limiting the medical investigations to violent deaths and requiring written autopsy permission from the district attorney, mayor, or selectmen of the district.[10]

In contrast to Massachusetts, the New York city Law enacted in 1915 authorized investigation by the medical examiner of deaths in New York city resulting from criminal violence, casualty, suicide, suddenly while in apparent health, or when not attended by a physician, or in prison, or in any suspicious or unusual manner. Furthermore, the decision to perform an autopsy rested entirely with the medical examiner. The Mayor of New York city appointed the chief medical examiner from the classified Municipal Civil Service List compiled on the basis of competitive examinations.[10]

The Medical and Chirurgical Faculty

In 1937 the Medical and Chirurgical Faculty of Maryland appointed a committee consisting of Richard T. Shackelford, MD, chairman; Manfred S. Guttmacher, MD, and Peregrine Wroth, Jr., MD, to investigate and study the coroner system in Maryland. The chairman, in 1938, made his report advocating the abolishment of the coroner system. The report was approved and the Faculty initiated the move to the medical examiner system. A satisfactory bill was drawn and presented to the State legislature on January 1, 1939.

However, Cecil County Senator C. Clyde Squires could "see no reason why we must hand over to the medical profession the internal affairs of the State."[11] As the result of an extension of home-rule courtesy, Cecil County was excluded by vote from the provisions of the proposed Post Mortem Examiner's Law.

This precedent immediately triggered the efforts of four Baltimore city senators to exclude Baltimore city. Of course, this would have voided the entire bill since the Office of Chief Medical Examiner was to be in Baltimore city. However, this effort was voted down, 17-12. The Post Mortem Examiner's Law was extended to include Cecil County in 1941.

The bill passed the legislature, but before Governor Herbert R. O'Connor had the opportunity to approve it, Aurelio Marco Tarquinio challenged the people of Baltimore city and their medicolegal representatives.

Baltimore's First Torso Murder

The news broke the East Baltimore evening with startling suddenness. "It's a hand down there—it's a hand,"[12] was the shout of an eight-year-old boy as he emerged with a rubber ball he had pursued into the sewer at Lombard and Chapel streets on Friday evening, April 14, 1939. The police

arrived and checked the sewer and came up with not one bundle, but two. The other contained a woman's lower leg, its wrapping a comic sheet from a Baltimore newspaper.

An hour and one-half later, at 7:30 PM, a second recovery consisting of heart, lungs, and other organs was made at Lombard and Wolfe streets.

A third recovery consisting of the right foot and lower right leg was made at 10:10 PM in a sewer at Lombard and Chester streets. Later during the same evening, Eastern District Coroner, Charles W. Wood, MD, after examining the parts at the City Morgue, stated that a murder had been committed within four to five hours prior to the initial recovery and that he had asked Howard J. Maldeis, MD, City post mortem physician, to perform an autopsy on the parts at the morgue.

The next day, Saturday, State's Attorney J. Bernard Wells asked Manfred Guttmacher, MD, medical advisor to the Supreme Bench; Frank Kindel, MD, pathologist at City Hospitals, and Carroll G. Warner, MD, pathologist at the University of Maryland Medical School to view the parts of the woman's body at the City Morgue and construct a description of her as she was in life. They agreed and went with the State's Attorney and William H. Maynard, Deputy State's Attorney, to the City Morgue. While they were making plans to move parts of the body to another laboratory, Dr. Wood rushed in and called a halt to proceedings.

"They will not enter this case until I want them in,"[13] said Dr. Wood. He is reported to have added that he did not believe in any "high falutin'" scientific procedures, and that he considered himself entirely competent to make whatever examinations were necessary.[14]

"It is incredible to me," said State's Attorney Wells, "that Dr. Wood is not allowing these men to aid at the earliest possible moment when they could do so much good."[14] He called Dr. Wood's attitude disappointing and appealed to Judge Emory H. Niles of the Criminal Court.

Dr. Wood declared he would not yield and said that he didn't believe any court had the power to remove him or dictate procedure to him. He added he believed that he was given full jurisdiction under the present law.

"I told Mr. Wells to get his writ and I'll be there with my lawyer to meet it."[13] Dr. Wood said.

Dr. Wood was called to the courthouse on Monday, April 17, for a conference in Judge Eli Frank's chambers. The conference was attended by the State's Attorney J. Bernard Wells; Dr. Wood; Max Sokol, attorney for Dr. Wood; Howard J. Maldeis, MD, City post mortem physician; Conrad Acton, MD, assistant to Dr. Maldeis; Lt. C. F. Schanburg, of the Eastern District; and William H. Maynard, deputy state's attorney. At the conclusion of the conference Judge Niles said that Dr. Wood, "Has acceded to Mr. Wells' request to obtain the cooperation of Dr. Kindel and Dr. Warner. . . ."[15]

On April 18, Tuesday, four days after the initial sewer discovery, State's Attorney Wells announced that he had engaged another pathologist to aid in the investigation, Harrison S. Martland, MD, chief medical examiner, Essex County, New Jersey. (Dr. Martland had distinguished himself in Orange, New Jersey, when he discovered that a number of girls and young women engaged in brushing numerals on watch dials with a luminous paint, through wetting their paint brushes with their tongue or their lips, had absorbed varying quantities of radium, many of them fatally.)

On Wednesday, the 19th, State's Attorney Wells issued a letter to Dr. Wood requesting him to sign an order for the release of the woman's remains to Dr. Kindel. Dr. Wood suggested that Mr. Wells issue his own order for the release. Mr. Wells signed an order for the release of the remains from the morgue and Dr. Kindel, with a patrolman on duty with the State's Attorney's Office, called at the morgue for the remains and took them to an X-ray laboratory at Baltimore City Hospitals. The X-rays would be placed before Dr. Martland when he arrived at noon on the 20th.

"If the X-ray studies which were begun by Dr. Kindel are successful," said State's Attorney Wells, "they may enable the medical authorities to arrive at a description of the woman which in turn might aid in establishing her identity. And, of course, they are expected to disclose the manner of her death. . . ."[16]

Meanwhile during the evening of that same Wednesday, Frank Marco (Aurelio Marco Traquinio) was taken from his home by the police. The police had been watching Marco since he had reported on the previous Saturday, two days after the initial sewer discovery, that Mrs. Evelyn Rice, his housekeeper, was missing.

When daylight broke on Thursday, a squad of police returned to Marco's house with picks and shovels and began to dig up the tiny back yard. The head, upper arms, thighs, and part of the torso were found buried in quicklime in the back yard of

the house at 110 S. Durham Street, a narrow street between Ann and Wolfe. This discovery made the body of the woman practically complete.

Five hours after the discovery in his back yard, Marco, at the Eastern Police Station, made a complete confession of the woman's murder and was charged with assaulting and stabbing his housekeeper with a butcher knife and thereby causing her death. (Later on he made another similar confession.)

Meanwhile, Dr. Martland had arrived, and he remained to help reconstruct the dismembered body and examine the head, the latter at Dr. Maldeis' request.

At the coroner's inquest held later that same Thursday, Marco denied any knowledge of Evelyn Rice's death, but Dr. Wood ordered Marco held in the City jail, pending action of the Grand Jury.

On April 24, the Grand Jury indicted Marco.

Marco pleaded not guilty and went on trial. On May 22, opening day, the last witness of the day, Dr. Maldeis, City post mortem physician, told the three judges, sitting without jury, that the cause of death was a fractured skull. He added that there were two incised wounds of the scalp, one penetrating to the brain causing hemorrhage. This hemorrhage did not result from a fall, concluded Dr. Maldeis.

In the trial's third day the State read Marco's two confessions, which told of constant reciprocal threats during the 10 to 11 months he had known Evelyn Rice. Evelyn, a twice-divorced former Georgia peach queen, came to the tavern in the 600 block Broadway in which Marco was part owner and asked for a job as barmaid. Shortly after she began work arrangements were made for her to operate the tavern and Marco went to work at Sparrows Point. However, Marco soon closed the tavern, finding it unprofitable, and Evelyn moved into his Durham Street home and became his housekeeper. During the night of April 13, Marco and Evelyn had words. Marco said that Evelyn attacked him with a knife; and while grasping her wrist, he struck her and she fell down the cellar steps. "I get a little mad, I get the knife and start cutting piece and piece. I done everything in one night,"[17] he was reported to have confessed.

After the State's reading of the confessions, Marco's attorney, Harry Adelberg, argued to the judges hearing the case that during the police interrogation, Coroner Wood's thrusting into Marco's face the severed head of the woman which had been dug from the back yard several hours before, constituted an exertion of improper influence on the defendant. Mr. Adelberg asked that the confessions thus obtained be excluded.

At the conclusion of Mr. Adelberg's argument there was a brief conference between judges, after which Judge Niles leaned forward and said: "We rule that both confessions are admissable."[17]

Previously during the trial a police lieutenant testified that the head had been shown to Marco for the purpose of identification and that he (Marco) had been asked whose it was, but the lieutenant denied that the head had been thrust into Marco's face.

Dr. Wood explained during his testimony, "I asked Inspector Mintiens if I should show him (Marco) the head. He said I should. All parts of the body were brought up to the room in a tub. I got the rubber gloves and picked up the head, placing it on the table. I said twice, 'Marco, look at this head,' then I said, 'Marco who is this?' He answered, 'Evelyn—Evelyn Rice.' "[18]

Marco testified that he made no confession until after being shown the severed head; nevertheless, the judges returned a verdict of first degree murder. The verdict could have carried a death sentence if it had not been for a later conference between counsel and bench where the defense attorney agreed to accept a life term and abandon pleas for a new trial motion.

On May 25, 1939 Marco was sent to the Maryland Penitentiary to begin his life sentence.

In November, 1954, after serving approximately 15½ years of a life sentence, Marco was released from prison. Then 60 years of age and tuberculous, he was no longer considered a danger to the community.

Maryland's Post Mortem Examiner's Commission

On May 1, 1939 the terms of all coroners expired. On May 11, 1939 the governor approved the bill that created the Maryland State Department of Post Mortem Examiners and established the Maryland Post Mortem Examiner's Commission of which the Office of the Chief Medical Examiner is the central administrative and functional arm. The Commission was composed of ex-officio members who serve without compensation. They were:

The Professor of Pathology of the School of Medicine, University of Maryland.

The Professor of Pathology of the School of Medicine, The Johns Hopkins University.

The Director of Health of the State of Maryland.

The Commissioner of Health of Baltimore City.

The Attorney General of Maryland.

In 1941, the Superintendent of the State Police, by an amendment to the law, was substituted for the Attorney General as a member of the Commission, thereby removing the Department of Post Mortem Examiners from any direct control by the legal department of the State and providing for close cooperation with the police agencies.

The commission is authorized and directed to appoint five medical examiners, one to be known as Chief Medical Examiner, and the other four as assistant medical examiners. At present, the chief and two assistants are certified in Forensic Pathology and Anatomic Pathology by the American Board of Pathology.

Of the two additional assistants one is certified in Anatomic Pathology and recently board eligible in Forensic Pathology, the other assistant is recently board eligible in Anatomic Pathology. A Toxicologist, Assistant Toxicologist, and an Immunologist are additional staff appointed by the Commission. At present each appointee is a PhD.

Compensation for all eight of the above is fixed by the Commission subject to approval of the Board of Estimates of Baltimore city and is paid by the Comptroller of the State of Maryland out of that portion of the funds collected by the Racing Commission otherwise payable to the City of Baltimore and the several counties.

Additional professional, technical, and clerical personnel, and other employees are also appointed by the Commission when authorized by the Board of Estimates of Baltimore. Such appointments are made in accordance with the Baltimore City Merit System. Compensation for such appointments is provided by the Board of Estimates in the Ordinance of Estimates of Baltimore City.

The Post Mortem Examiner's Commission is also authorized to appoint a Deputy Medical Examiner for each county from a list of qualified physicians submitted by the medical society of the respective county. In Maryland's 23 counties there are 29 deputies, it being necessary to have more than one in larger counties.

Dr. H. J. Maldeis, Chief Medical Examiner since the inception of the Medical Examiner System, died January 15, 1949. Russell S. Fisher, MD, was appointed Chief Medical Examiner on September 1, 1949. The Post Mortem Examiner's Commission is the official head of the Maryland Department of Post Mortem Examiners and is the policy-making body for the system. The Chief Medical Examiner serves as secretary to the Commission and is charged with the supervision of the first centrally directed state-wide medical examiner system in the United States. At present, headquarters is at 700 Fleet Street in Baltimore, but a new building to house the Office of the Chief Medical Examiner is presently under construction at the corner of Pratt and Penn streets, close to the University of Maryland Hospital and Medical School, and will be completed by April, 1969.

Under The Post Mortem Examiner's Law, Baltimore city is responsible for providing, equipping, and maintaining in Baltimore city a building to serve as the headquarters of The Office of the Chief Medical Examiner and Assistant Medical Examiners. The present building at 700 Fleet Street was constructed in 1924 and its facilities are inadequate for the present volume of work.

An "M. E. Case"

Throughout the United States competent legislation requires that between 15 and 20% of all deaths be investigated by an official agency.

In Baltimore city or in any county of the State a "Medical Examiner's Case" is any death which is the result, wholly, or in part, of a casualty or accident, homicide, poisoning, suicide, criminal abortion, rape, therapeutic misadventure, drowning, or a death of a suspicious or unusual nature, or of an apparently healthy person. Whenever a physician, funeral director, or other person shall have knowledge of a potential medical examiner's case, it should be reported without delay to the police or sheriff who has jurisdiction. It is the duty of the police or sheriff immediately to notify the Office of the Chief Medical Examiner or a deputy medical examiner as the case may be, and the State's Attorney of Baltimore city or of the county, as the case may be, of the known facts concerning the time, place, manner, and circumstances of such deaths.

In the case of any death during anesthesia occurring in the City of Baltimore, the hospital wherein the death occurred shall notify immediately by telephone the Chief Medical Examiner or one of the Assistant Medical Examiners who shall conduct the investigation necessary to determine if it is a medical examiner's case. In the case of death during anesthesia occurring in any county of Maryland, the hospital shall notify immediately, by telephone, the Deputy Medical Examiner of the county wherein death occurred.

Baltimore City Medical Examiner Cases

In the City of Baltimore, the first notification of the Office of the Chief Medical Examiner regarding a potential medical examiner's case is usually from Police Services at Central Police Station. Police Services, having been notified of a death thought to be a medical examiner's case, contacts the lay investigator on duty at the Office of the Chief Medical Examiner and gives him the available information. The Office of the Chief Medical Examiner is open 24 hours a day, every day. It is the job of the lay investigator on duty to get the basic information about each case from the police and other sources. The lay investigator then decides within broad limits how to categorize the case. If necessary, he contacts the medical investigator or the medical examiner-on-call for instructions as to how to proceed.

Should medical questions arise during this stage of the investigation, there are four medical investigators, one of whom is available at all times to discuss problems of a medical nature. Usually the appointments as medical investigator are held by physicians in resident status in forensic pathology at the Office who combine their investigative duty with training in medicolegal pathology. This training is of such calibre as to be accepted by the American Board of Pathology as partial fulfillment of the requirements for certification in Forensic Pathology or Anatomic Pathology.

It is the job of the medical investigator to investigate the medical background of the case and to ascertain whether the case reported to the Office is properly a medical examiner's case, whether it needs to be referred for immediate action to one of the medical examiners, or whether it can be released for autopsy to a hospital "on approval" of the medical examiner on duty. In those reported cases with hospital treatment, the hospital's record room is requested to provide medical information and hospital cooperation is excellent.

During the 12-month period ended June 30, 1968 there were 4,593 deaths in Baltimore city reported to the Office of the Chief Medical Examiner as potential medical examiner cases. Of these, 3,274 were found after investigation to come under the jurisdiction of the medical examiner and the death certificate was ultimately issued or countersigned by the medical examiner.

Investigation also revealed that 1,319 of the reported cases were not medical examiner cases and jurisdiction was refused. It should be pointed out that before a final decision to decline jurisdiction is reached, a non-medical examiner's case may require as much investigation as an accepted case. Non-medical examiner cases include those in which a physician has been in regular attendance, but at the time of death, which is unexpected, he cannot be contacted promptly. The medical examiner makes an effort to locate him. If successful, and if the physician's information satisfies the medical examiner that the death was due to a known natural cause and the physician states that he will sign the death certificate, the case is declined by this office. However, if the regular physician cannot be located within a reasonable period of time, the medical examiner may accept jurisdiction.

Once it has been established that the case needs to be examined at the Office of the Chief Medical Examiner, the medical examiner's morgue wagon is dispatched to the scene of death. Occasionally, by virtue of his experience, a lay investigator at the scene will recognize or suspect that a death is an hitherto unsuspected homicide. When this situation arises, he secures the scene and calls the medical examiner on duty who proceeds to the scene. In cases where death is known to be due to or is associated with unusual circumstances, the medical examiner goes to the scene to conduct his investigation and to examine the body before the scene is disturbed.

Once the body is brought to the Office of the Chief Medical Examiner, it is examined by the medical examiner on duty. The extent of the examination will vary from an external inspection to a complete autopsy, with or without toxicological analysis, depending upon the circumstances of death, the medical history (if any) and the findings on external examination of the body. The cause of death is then certified, the death certificate filled out, and the body released to the funeral director who has been contacted by the family.

Approvals and Inspections

From July 1, 1967 to June 30, 1968 the 1,415 deaths in Baltimore city that came under the jurisdiction of the medical examiner and required no autopsy consumed the least amount of time and effort. These are "approvals" or "inspections." "Approved" cases are those in which telephone or personal contact with the deceased's physician, family, any witness to the death and the police department provides sufficient information for the medical examiner to determine the cause of death without having the body brought to the morgue, and the physician is willing to complete the death

certificate. In many of these instances the deceased is an aged individual who has incurred a fracture of some type. This being an accident automatically requires that the death come under the jurisdiction of this Office; however, inquiry reveals that the death of the individual was brought about by some heart ailment that was present at the time, or by pneumonia, or some other natural cause, and an autopsy is not necessary to determine the cause of death. After clearing the case with the medical examiner on duty, family permission may be requested by the physician to allow the hospital pathologist to perform an autopsy, the findings of which are supplied to the medical examiner for his files. The physician completes the death certifcate and it is subsequently countersigned by the medical examiner.

Other "approvals" include cases in which a physician not in regular attendance on a patient pronounces death. Inquiry by the medical examiner's office of the deceased's regular physician reveals that the cause of death is obvious. The pronouncing physician is requested by the medical examiner to sign the death certificate on the basis of his firsthand knowledge and the further information disclosed by the medical examiner's investigation. Again the death certificate is countersigned by the medical examiner.

"Inspections" are those cases which require an external examination of the body by the medical examiner in addition to acquiring a history before conclusion as to the cause of death. Certain highway casualties come under this category; also many of the so-called "heart failure" deaths. The deaths in the latter category are similar to "approved cases," except that no physician is available at the scene to verify the symptoms of the disease that brought about death, and the medical examiner acts in this capacity and signs the death certificate.

County Medical Examiner Cases

Primary investigation of county deaths coming under the jurisdiction of the Post Mortem Examiner's Law is made by the deputy medical examiner in each county. These men are required by the law to be physicians. They are notified directly by the police and upon notification, visit the scene of death and conduct the necessary investigation. If their investigation reveals the cause of death, they issue a death certificate and release the body. If in their opinion a post mortem examination is necessary, they may, after consultation with the chief or assistant medical examiner, order an autopsy. The deputy medical examiner receives for each death investigated not less than $25, and not more than $50, payable from the funds of the respective county.

The Autopsy

All of the autopsies performed on Baltimore city medical examiner cases are required to be performed at the Office of the Chief Medical Examiner, unless other special arrangements are made. Those cases requiring autopsies in Anne Arundel, Baltimore, Calvert, Carroll, Cecil, Charles, Harford, Howard, and St. Mary's counties are also brought into the Office of the Chief Medical Examiner in Baltimore city. For the remaining counties of the State, the majority of the autopsies are performed in the county by hospital pathologists approved by the Chief Medical Examiner to conduct medicolegal autopsies. The necessary expenses for transportation of the body in the counties for autopsy by the medical examiner or approved pathologist are paid from Racing Commission funds. A fee is paid from the same funds to the approved pathologist for each medicolegal autopsy he performs.

It is in those cases requiring an autopsy for determination of cause of death that the real purpose and need for a medical examiner system is seen. Approximately two thirds of the medicolegal autopsies in Maryland are performed at the Office of the Chief Medical Examiner. In a total of 1,859 autopsies performed at the Office of the Chief Medical Examiner during the 12 months which ended June 30, 1968, there were 106 partial autopsies. In a partial autopsy the medical examiner has been supplied sufficient information to suspect the cause of death before opening the body, but requires confirmation before certification. The body is opened to view and confirm the suspected area of disease, but no tissue is removed. Certain natural and many of the accidental traumatic deaths fall into this group.

The time required for the performance of an autopsy will vary depending upon the amount of tissue dissection and subsequent study necessary for determination of the cause of death. Gross inspection and dissection of the organs may enable the medical examiner to state the cause of death. However, this is not true in every case and then microscopic or toxicologic study is necessary.

To avoid any inconvenient delay a "pending further investigation" death certificate may be

issued by the medical examiner to allow legal transportation and burial of the deceased. The Health Department is notified by the medical examiner when the cause of death is established, and the death certificate is then completed.

Toxicology

During the year ended June 30, 1968 approximately 6,000 chemical determinations were performed on the 1,685 medical examiner cases requiring toxicologic examination. In about one half of the cases there was a positive toxicologic result. Actually, the cause of death was revealed by toxicologic methods in approximately 125 cases, including 44 due to carbon monoxide, 24 due to barbiturates, 23 due to narcotics, and 20 due to acute ethylism.

N.A.S.H.

Original copies of all medical examiner case records throughout the State are forwarded to the Office of the Chief Medical Examiner for permanent filing.

Records at the Office of the Chief Medical Examiner reveal that in approximately 65% of the medical examiner cases, the manner of death is natural. Accidental deaths including highway and occupational casualties, account for another 25%. The remaining 10% is split between suicide and homicide, 6% and 4% respectively.

Education And Research

A medical examiner system in addition to conducting routine investigations of death must, if it is to maintain high scientific standards, participate in teaching and research activities along the lines of medicolegal practice.

The staff at the Office of the Chief Medical Examiner is responsible for lectures and laboratory demonstrations in Forensic Pathology including Toxicology to the sophomore medical students of the University of Maryland Medical School, a lecture series to the junior medical students at the University of Maryland Medical School, a lecture course to the senior law students at the University of Maryland Law School, and instruction of members of the United States Air Force and other graduate students working for a Master's Degree in Public Health at The Johns Hopkins School of Hygiene and Public Health.

Additional lectures and demonstrations are given periodically to recruit classes of the Baltimore City Police, Maryland State Police, Anne Arundel County Police, and the Baltimore County Police. Members of the staff also lecture to various lay and professional groups.

This past April, there was brought to Baltimore a national seminar on homicide investigation. Previously, the Francis Glessner Lee Seminars on Homicide Investigation, attended by a select group of police officers from all over the country, have been held at the Harvard Medical School, which last year closed its Legal Medicine Department. It is expected that these seminars will be continued twice yearly after the Office of the Chief Medical Examiner occupies its new quarters at 111 Penn Street.

On July 1, 1968, the Office of the Chief Medical Examiner with the support and cooperation of the Department of Transportation, United States Public Health Service, and UAREP (Universities Associated for Research and Education in Pathology) began a 12-month in-depth investigation of a significant number of vehicular deaths occurring in urban, suburban, and rural settings.

This study includes specifically the following:

- Investigation of the accident scene
- An autopsy with special emphasis given to correlation of the injuries with those items in the vehicle which appear to have been responsible for the pathologic lesions. This includes X-ray examinations of the cervical vertebral column.
- The role of alcohol, drugs, and other chemical agents, especially carbon monoxide.
- Mechanical defects in the motor vehicle as determined by a consultant mechanical engineer.
- Psychological factors—investigation in this area is made by trained psychologists with part-time participation by a psychiatrist.
- The recording of autopsy observations and ancillary data in such a manner that it will be readily adaptable to automatic data processing at the Registry of Accident Pathology of the American Registry of Pathology located at Armed Forces Institute of Pathology in Washington, D. C. In this fashion, we are field testing the "standard accident autopsy protocol" now being developed by UAREP.

Other research projects in the office include studies of the mechanism of drowning, methods for detecting new drugs in tissues, and a search for the cause of sudden death of infants (the so-called crib deaths).

". . . What better way to assess a society is there than to know how many of its children are dying at home without medical attention, how many of its mothers are dying from septic abortions, and how many of its fathers are dying at work in hazardous environments? Forensic pathology, then, is the study of the ecology and the nature of human death. It is the study of public deaths, and those of concern to the public at large. It is meant to aid the living . . . ."[19]



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Leaves from a Doctor's Notebook*

Only a few of us are descendants of medical men, hence the majority of us have little concept of the life and work of our colleagues in this country in the middle of the last century. Wrapped up as we are in our own problems of medical economics, it might be interesting to enlarge our perspective a bit by having a glance backward into the life of a typical successful practitioner of the late sixties.

A Century Ago...

H. M. F. BEHNEMAN, MD,
San Francisco

As we review some of the interesting highlights of this individual, we find that he, too, had his problems related to fee schedules, isolation from medical centers, libraries, and medical journals. The patient's life and the doctor's success depended solely upon the latter's ability to properly use his sense of touch, hearing and observation. He had none of the armamentarium of modern equipment, and none of the specialized help we've gained in the development of the basic sciences. His medical education was begun working at the elbow of a preceptor, then followed by 18 months in a medical school, few of which then existed.

Anatomy and surgery were all-important; there was a smattering of chemistry, materia medica, therapeutics, and obstetrics (with the aid of a mannikin). But there was no bacteriology, pathology, organic chemistry, pharmacology, X-ray, radium. There was no specialization in practice. The graduate left school to do everything, without internship, without a residency, but starting his chosen profession with a brave heart, and often braver patients. Such a man, in every sense of the word, is Hiram Buhrman, MD, who was born in Boone Township, Indiana, September 3, 1822. His family shortly before his birth, had made the long trek from the Blue Ridge mountains of Maryland to Indiana in the "far west."

Unhappy in their new flat-country environment, they soon returned East with this infant Hiram held in front of his mother on the saddle day after day. He had as much education as the young boy of that day could obtain in the Maryland hills. He worked hard in physical pursuits and labor. As the years went on, he overcame many obstacles to fulfill his determined ambition to become a doctor of medicine. He taught school in Boonsborough, Maryland, later owned a drugstore, and was a member of the Maryland legislature in the 1860's. His wife, the mother of his three children, had died before he started the study of medicine.

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Thus at the rather advanced age of 44 years, he entered Jefferson Medical College in Philadelphia, after having served his preceptor, one Leander Wachter, the required time. On October 23, 1866, he entered Jefferson Medical College, and on March 7, 1868, 18 months later, he received the degree of Doctor of Medicine, being one of 159 men in the graduating class that year. Dr. Buhrman's thesis subject was "Erysipelas."

He returned to Maryland to carry on the practice during most of his life, practicing in various places, principally in Chewsville, Mechanicstown (now called Thurmont) and Funkstown, Pennsylvania. In those days the horse was the principal means of transportation, and interestingly enough, a doctor was judged by his fellow citizens by the number of horses he was able to maintain. Hence, the less busy practitioner who could afford but one horse, became known as a one-horse doctor, and we still use the term in the same derogatory sense.

The method of attending classes in those early years was by purchase of cards from the individual professors, entitling the student to attend the lectures given by that teacher. These were purchased from the Dean and presented at the lectures. They were individual, valued passports to medical education, and they have become important items to collectors of medical Americana.

Of the seven professors from whom he purchased tickets, one was Robley Dunglison (1798-1869) of Heswick, England, who compiled an excellent medical dictionary and wrote an amazing array of textbooks on nearly every subject except surgery. He was professor of medicine. Dr. Buhrman's professor of anatomy was Joseph Pancoast (1805-1882) of New Jersey, who in 1872, first successfully excised the fifth nerve for neuralgia, and was the first to perform a successful plastic operation for exstrophy of the bladder in 1858. His professor of surgery was Samuel D. Gross, the greatest American surgeon of his time. (His statue stands by the Army Medical Museum in Washington.) He was the greatest of the German-American physicians. Dr. Buhrman's professor of the practice of medicine was Samuel Henry Dixon (1798-1872), an elegant and attractive medical stylist and literateur. He was a pioneer and eminent medical teacher. Ellerslie Wallace was professor of obstetrics, Howard Rand professor of chemistry, and John Biddle was professor of materia medica.

We have a pretty clear idea of the general run of a practitioner's life in those days, therefore, I wish to stress a subject of particular interest to us now, that of *fees and the payment of bills owed the physician.*

I have to think of the shouts of utter joy we would hear from Sacramento if some of the politicians could get hold of the fee schedule from the days of Dr. Buhrman. An office visit was then known as a "call," whereas a "visit" meant a visit by the doctor to the patient's residence. The regulation fee for a call at the doctor's office was 25¢. This included medicine, unless of course expensive medicine was necessary, wherein an extra amount was added to the bill. Owing to the fact that the doctor of the time compounded his own prescriptions, I found little evidence of his therapeutic formulae. One, however, of interest is labeled a "tonic mixture." It consists of whiskey, morphine sulphate, tincture of ferric chloride and quinine. Each dose, which a patient is supposed to have taken three times a day, contains two teaspoons of whiskey, one third grain of morphine sulphate, five grains of quinine, and a stout dose of iron chloride. Certainly, after the fifth day on that tonic the patient was either quite restful, or fearless even of his mother-in-law. House visits within the township limits were 50¢ regardless of the time spent in administering to the patient, except in the case of being detained by death, which uniformly was a $3 fee. At that time, of course, the doctor did most of the work of the present-day mortician.

Dr. Buhrman was physician, surgeon, lawyer (as there was none there) and, of course, the dentist. All tooth extractions were 25¢, and when a few in a row were removed the fee per tooth was less than that. When chloroform was required for tooth extraction, the total charge for the anesthesia and extraction was $2. All obstetrical cases, regardless of the length of labor, were $5. Abortions were also $5, while miscarriages ran a poor third at a $1.50. In a careful analysis of these account books of Doctor Buhrman, I have found only two instances wherein he made more than one house visit after delivery, and this was usually the following day. If he did visit thereafter, there is no charge recorded in any of these accounts listed in his books. It appears, therefore that the women of those days could take it and like it. On the other hand, maternal and infant mortality was high. The fee for setting and

caring for a fractured clavicle, including always all material used in the dressing, was $5. The reduction of a hernia was the same price. A house visit without medicine was 50¢, and with medicine 75¢. Setting a fractured arm or a shoulder was $5, whereas a fractured thigh brought $10, that being the sum total for proper care. Lancing an abscess or a felon was 50¢. And thus the fee schedule runs on.

Frequently, in these volumes I have found the notation: "Patient in the hands of the constable." Very often there is a notation: "This bill settled by a note." A careful study also reveals that 30 to 50% of the doctor's bills were paid in merchandise of various sorts. The following items I feel would be of the most interest to us, and I present them as they occurred in turning the pages of the large account book. The items mentioned are entered as a part of the individual account and credit is given for the merchandise brought to the doctor; the remainder due was sometimes paid in cash, in labor, by promissory note, etc.

One and a half days farm labor: $2.00.
One set of harness: $22.00.
One hundred pounds of flour at five cents a pound: $5.00.
Three chickens at twenty cents each.
Six pounds of honey at sixteen cents a pound.
Fifty heads of cabbage at four cents: $2.00.
Half a bushel of turnips: $.25.
Ten bushels of oats: $.25.
Six pounds of honey: $.15.
Thirteen pounds of butter and four pounds of lard.
Five-dozen dill pickles.
A barrel of lime at forty-five cents.
Four and a half days masonry: $7.25.
Seventy-two sheaves of fodder: $1.80.
Butter: twenty cents a pound. (This was a frequent contribution.)
Potatoes (many bushels) at fifty cents a bushel.
One pair of boots: $8.00.

Some patients poured their money back to him in the form of vinegar at 2¢ a gallon. There are several turkeys at $1 each; several tons of coal at $6 per ton; 193 lb. of beef at 7¢ a pound; many cords of wood at $4 a cord; one and a half day's plowing, $2; and many tons of hay at $6 a ton. One grateful patient paid with five dozen dill pickles totaling 50¢. Another patient received credit on her account for a $1.63 for 15 lb. of pork and four quarters of beef, and 29 lb. of corn meal at 1¢ a pound.

And last, but not least, on the credit side, one sees a line drawn across the total bills for varying amounts from three to twenty-eight dollars, with a notation underlined, "Credit at the bar." Most of this was at Shank's Tavern, and interestingly enough, only in the winter, from November to May. This is of particular interest in that it goes to show that he was human, and a feat in that at his death he received a eulogy in the local papers as a good Methodist! Certainly, a long hard winter entitled him to a little fire-water. His transportation nine months of the year was horseback or sleigh. In bad weather, day and night, he was a welcome figure in his long black rubber cape thrown completely over his head and body, and most of the horse as well. And even in good weather some of us might prefer whiskey to dill pickles, turnips, and livestock being deposited in our reception rooms.

He also had the worries of stabling, feeding, saddles, collars, fiynets, halters, whips, lap robes, sleigh and harness bells.

There was no mail delivery then. There was one medical journal in existence which he subscribed to, entitled *The Medical Bulletin,* edited in Philadelphia, costing him a dollar a year. He sent no bills; when money was needed, he was reminded of it by his good second wife, who also bore him three children. He then would set out in person to his patients, garnering what he could to fill the purse or the larder. He was not rich in worldly goods, but he lived in the biggest house, was a leader in his community, and the family lived simply yet well.

Dr. Buhrman practiced medicine 24 years, graduating from medicine at the age of 46, and passing at the age of 70, the father of six children. The following is a quote from the weekly paper of Hagerstown, Maryland, in June 1892: "He was always a very careful practitioner, well informed in medical knowledge, and built for himself a large and influential practice. Doctor Buhrman was a good scholar and conversed most intelligently on any subject. He was highly regarded for his good character, much loved by his family, and well admired by all who knew him. He was a member of the Methodist church." In a letter, a colleague from Maryland who, as a youngster, saw Dr. Buhrman writes of the distinct impression made on him when he first saw him: "his erect, stern, commanding figure was impressive, yet he was kind, and genial, positive and assured."

He too had his problems in getting his education, working in the rigors of a country practice

with its physical hardships of which we know not. He charged small fees in return for the investment he had made, and he had difficulty in collecting even part of them. These are our problems, they were his problems. It is just the story of another honest pioneer of American medicine—the will to become a doctor, the sacrifice to succeed with a job well done. Time and politics may change our hours and our fees, but they never change the man.

Remarks by Mrs. J. P. Downin, Daughter of Dr. Buhrman

Mechanicstown was a village of about 1500 inhabitants, located at the foot of the Cacoctin Mountains, a spur of the Blue Ridge, about 50 miles from Baltimore. It boasted six churches, two general stores, and one drug store. Our home was a twelve-room brick house with a vegetable garden, barn, chicken house, and a pump in the rear. There being no plumbing in the town, an outhouse, or privy, was at the lower end of the garden, with, strange as it may seem, a large bed of lilies of the valley next to it. My father's office was in the back parlor, and for all this the rent was $12 a month.

Father's visits in summer were usually made by horse and buggy; in rainy weather with its bad roads, by horseback; and in winter when it snowed, by sleigh. Our winter supplies such as a quarter of beef, hogs ready for curing, as well as corn, hay and straw for the horses, just seemed to appear. Some of the farmers paid their bills in that way. One basement room was usually filled almost to the ceiling with corn. Twice a year Mother would go to Frederick to buy our wearing apparel. Father would then start on a trip of collection. Mother used to say he was a poor collector. A small town doctor was a servant of the public. Once, after a great deal of correspondence with the pension attorney at Washington, Father succeeded in getting a Civil War back pension for a man named Miller, who, after he got it, refused to pay his bill. I remember Father saying he was the meanest man he ever knew. On another occasion I recall Father coming home from seeing a patient, and when Mother asked him, "How is Mrs. So and So?" he replied, "Oh, she is better. She said the last medicine I gave her did her a lot of good." As a matter of fact it was rain water and salt!

Everyone raised his own vegetables, and twice a week when we heard a horn blowing we knew it was the meat man coming. In season it was a fish wagon, too. It was a contented life. We had very little money, but everyone was happy. Our social life consisted chiefly of church picnics in summer, when Father invariably received a call, so that Mother would have to take us alone. During the Presidential parades, which were one of the highlights of the town, all the houses of the party parading had a light in every window, while the houses of the opposing party remained dark. It was thus apparent who were Republicans and who were Democrats.

About 15 years ago I passed through the old town and called on Dr. Birely, who now owns the old home place. "Morris," I said, "I want to see the old barn."

"I have no barn. No use for one."

"Well, then, I want to see the old privy."

"Have no privy. We've plumbing."

I had a lumpy feeling in my throat, for I had expected the place to be just the same. It was hard to realize that after all these years the town had gone modern. The only thing that remained the same was that Dr. Birely also kept his office in his home. Even the lilies of the valley were gone.

As the lay public might expect, and as the legal profession would be certain of, the medical profession has jargon to cover the multitude of sins that are the subject of these remarks. "*Iatrogeny.*" It has been defined as: Remarks made by a physician, even in an off-hand way so as to induce a pathological psychiatric condition. The patient builds a minimal suggestion to great proportion. He may develop a limp or some other abnormal response to adequately play the role he thinks he ought to assume. His whole personality may warp to a degenerated state, and may not revert to complete normality even after the settlement of his case, or, as the lawyer might say, even after there has been a complete recovery ($$) in his suit against the offending physician.

Office Dos and Don'ts From a Legal Standpoint

JOHN F. KING, ESQ.

This iatrogenic phenomenon is one of which medical assistants (paramedical people) should be aware and with sensitive disciplining seek to avoid. The following are some Dos and Don'ts which will hopefully promote this end.

Do Not Comment on Tests (X-rays, etc.)

Cases have been known to arise because of the overheard casual, presumably sympathetic, remark made by a technician to the effect that:—"My, that's a high blood count," or, the X-ray technician who was overheard to opine casually to a co-worker, "That's an unusual fracture." Such remarks obviously stir the patient to apprehension, in effect—set such a patient up as a potential claimant if the doctor, in the patient's mind, does not appreciate the novelty of his case.

Do Not Proscribe the Doctor's Practice

A patient has been known to confer with counsel upon realizing an unsatisfactory result (not to be unexpected from the particular surgery) when the doctor's receptionist, upon the patient's initial visit, indicated upon a brief history, "I don't remember ever seeing a case like this before." It was only after careful explanation by another doctor that the patient was persuaded not to pursue legal action charging the physician with failure to seek consultation.

Do Not "Curbstone"

The lawyer is careful to indicate when talking nonprofessionally on a subject touched with legal questions that he is giving a "curbstone opinion." Paramedical people should not wander into medical opinions of any sort for fear of mistakenly prejudging the physician's evaluation of the case and stirring up doubt and uncertainty in the mind of the patient. Example: In the spirit of sympathy,

"You should have no trouble with this," when spoken to a patient who subsequently does have trouble, makes such a patient mistakenly suspect fault by the doctor.

Do Not Prescribe

Such an admonition should hardly be necessary to a knowledgeable paramedical person who, more than the usual lay person, is sensitive to the great destruction which can be wrought by a misprescribed medication. However, paramedical people are not sufficiently sensitive to their own importance in the eyes of the lay person so that even a casual remark to a waiting patient by some lady in a white coat, "Have you tried diet pills?" may cause the person to seek such medication. In a more severe case a medical secretary renewed a prescription for diet pills when her doctor-employer was on a military tour of duty. The motive, of course, was to help the poor patient, but when he subsequently suffered a blackout and an automobile accident ensued, she found herself, as well as her doctor-employer, defending a law suit.

Do Not Treat

This is another admonition which should not have to be made, but the medical assistant is not always sensitive to the meaning of "treatment." The best standard to adhere to is that treatment is the laying on of hands—the touching of the patient. Even the removal of an ostensibly insignificant band-aid can be followed by a gangrenous condition requiring ultimate amputation. The example is farfetched to illustrate the danger, but persons who are not Registered Nurses should literally keep their hands off the patient. Even the solicitous touch may constitute assault and battery to the disgruntled "injured" patient.

IM injections ought not to be given by someone who is not a Registered Nurse. Obviously IV injections ought not to be given by untrained people, but the dangers of an IM injection are not so obvious, and the practice of their being given by medical assistants is increasing. Even the careful IM injection, in rare cases, can cause a footdrop or wristdrop. Such a result is difficult enough to defend when it follows an injection by a qualified person. It is totally indefensible when it follows an injection given by someone unqualified.

Do Not Violate the Doctor's Confidential Relationship

This tenet is most frequently breached because of a lack of awareness. It is not uncommon to walk into a doctor's offices and find correspondence open to the eye of any patient on the secretary-receptionist's desk. It is a usual experience to overhear appointments being made by the receptionist on the telephone with such remarks as, "Yes, Mr. Jones, the doctor can see you at 10 AM. Your street number is so and so. Have you had a relapse or is this something new? etc., etc." You have perhaps had the revealing experience of seeing specimen bottles on the technician's shelf, clearly identifying the patient, marked forebodingly, "Positive." Such examples are all unwitting violations of the doctor's confidential relationship with his patient, a relationship which the patient is most gratified in having the medical assistants respect. The use of the telephone so as not to speak out the patient's name or the use of labels so as not to disclose his personal identity are just some of the ways (confidentially), which, when observed by the patient, gives him a greater feeling of security and loyalty to the doctor, as well as his staff.

Budget the Doctor's Time with His Health as well as the Patient's Health in Mind

This is an exceedingly difficult task for today's medical assistants. Doctors, it seems, are always in a hurry, but the trick is to avoid the appearance of it. The constant and regular use of the telephone to and from the scurrying doctor can often prevent unnecessary sojourns for him. The doctor who is kept posted on his appointments keeps them better. It is a good habit to review tomorrow's cases with the doctor before the end of the preceding day. Teamwork between the physician and his staff, I think, is the important thing here, but it must be teamwork with the doctor's welfare in mind. The rushed, overworked physician, while perhaps "the most successful," is also the most prone to error and therefore the most sued.

Handle the Urgent Case as Such. Do Not Fall Heir to "Wolf! Wolf!"

The medical assistant observing a doctor handle a patient is unaware of the judgment which the physician exercises in decision making. But, the medical assistant, after seeing the doctor satisfy a patient by putting him off a number of times, may decide that such a patient can now be put off, as it were, by the medical assistant. So it was when an expectant mother called in for the fifth time, still exclaiming the urgency of her condition. The assistant, aware of four prior false starts, unfortunately undertook to evaluate the

fifth call as just another "Wolf! Wolf!" This was no excuse for the doctor when he was sued for injuries arising out of the delivery of the child in transit to the hospital. Medical assistants must not evaluate the genuineness of the patient's proclaimed emergency. This must be put promptly to the physician for his sole and exclusive determination.

Suggest to the Doctor (Consistent with the Confidential Relationship) the Frequent Use of Carbon Copy "CC"

The doctor has an obligation to consult and to advise articulately, preferably in writing in order to avoid error. It is always appropriate to inquire, "Shall I send a copy to Dr. Jones?" If he is the referring physician, communications with him must be maintained and "CC" is an easy and efficient system.

Keep the Patient's File Medically Germane

Ideally, there should be two files for each patient, one the patient's, the other the doctor's file. The rule for filing should be: when in doubt as to the document's being medically germane, place it in the doctor's file. The following matters are usually not medically germane: correspondence with attorneys, liability carriers for the doctor, collection agents. They should be kept in the doctor's file, and placed next to the patient's file. In one case a reference to the patient in his file by research number, not medically germane to the patient, erroneously suggested that the doctor was experimenting with the patient. The unfortunate inference would not have been drawn had the reference been filed in the doctor's, not the patient's file.

Do Not Suggest a Conspiracy of Seclusion or Preference

The patient who is told, "He has signed out, supposedly, but I know he is here and will speak to you," will positively be persuaded when he is told the next time, "I am sorry, the doctor is out," that the little conspiracy is now working to seclude *him* from the physician and that the preference is now being exercised for someone else not nearly so sick. If the doctor is out—he's out! If he turns out to be in and so indicates privately to you, then call the patient back, but do not indulge in suggestive subterfuge.

Avoid "Gobbledegook" Where Plain Lay Language will do

All of us on the perimeter of the medical profession like to demonstrate our association by using medical terms. We are not really qualified to use the terms and can cause trouble when we do. Example: "The doctor wants you to return in three weeks for an X-ray review of the femur." The word "leg" would cover the situation just as well, and indeed better, where the femur had not been fractured at all, but some other bone which, when it failed to heal in the expected manner, caused the patient to believe that the *doctor* did not even know which bone was involved. The use of the words of expertise encourages further inquiry by the lay person and ultimate deeper water for the medical assistant to the point where finally the pseudo-expert must say, "I do not know." The patient is then, of course, convinced that if the medical assistant (expert) doesn't know, neither does the doctor. Use plain language. Jargon is for physicians, between physicians.

Frankness and Candor Better Prepares the Patient

Do not conjure up false security for the patient. If the doctor will not be there waiting for a patient at the hospital, state that frankly to the patient, explain why (he must be at another hospital, for instance, or with some other patient) and reassure the patient that he will be tended to by the medical staff until the doctor arrives. Call ahead and alert the hospital of the patient's arrival and of the doctor's whereabouts. Nothing is more disquieting to an anxious patient than to hear the name of his physician being called over and over again on the hospital PA system, only to have it followed by his absence without any other knowledge. The informed patient will not consider that he has been abandoned.

Do Not Disclose Second Choices

The patient who gets a bad result will always, as is human, seek to determine why. A bad result may, and usually does, occur even in the presence of the legally required "due care and caution." But, the patient will be hard to persuade who has been told, "He tried to get you into Hopkins, but they had no empty beds," or who overheard the conversation for consultation, "Dr. Jones would rather have him seen by Dr. Green, but if he's on vacation, I suppose Dr. Brown will do." Arrangements for hospital admissions and for referrals

should be made out of the presence of the patient so that he will not be troubled by these second choices. He should be advised of such arrangements only when they have been confirmed and to which he then, of course, must consent.

Do Not Destroy the Files

The Statute of Limitations on malpractice action is difficult to fix because an injured patient may sue in a timely manner any time within three years of the date of the act of negligence or within three years of the discovery of such act of negligence. Discovery by a reasonable and prudent person of a medically negligent act may be delayed for years. Practical considerations require that we live with hopes that the doctor will not be sued and not be buried under a pile of dead files. It should be safe to destroy the file five years after the last treatment rendered the patient, if he was an adult patient. The Statute of Limitations for infants permits them to bring timely suit within three years of their 21st birthday, so that an infant's records ought not be destroyed for at least a period of five years from the date of his 21st birthday.

Use "Dictated but Not Read"

Where this is à fact, it can be a shield not only to the physician but also to the erring secretary. She, of course, is not expected to be completely knowledgeable in medical matters, and the physician is not expected to know something which he has not read. Conversely, a letter or consultation note should be checked for accuracy before acted on in the face of "dictated but not read." It may contain a typo and still make sense.

That's an idea! "Dictated but not read."



Maryland's Alcoholism Control Law and the General Hospital

It seems to me that a good way to start a discussion of Maryland's new Alcoholism Control Act is to acknowledge the contribution of Leroy Powell of Austin, Texas. Our most recent information about Leroy Powell goes back a couple of years. As of that time he was a chronic alcoholic, in the vernacular a "wino." He had a family he did not support. When he worked he shined shoes earning about $12 per week, some weeks. Most of the money went to buy wine which he drank every day. He got drunk on wine about once a week. When drunk he went to sleep, usually on the pavement.

FRED OKEN
Assistant Attorney General

Among his approximately 100 convictions for public drunkenness was a conviction in December 1966. The offense charged was the violation of an Austin ordinance that made it a crime to be found drunk in any public place, or to be drunk in a private home other than one's own home.

On that December day Leroy, having once again lost the battle to quench his unquenchable thirst, encountered a policeman as he staggered down the street. His speech was incoherent and he smelled strongly of alcohol. A peaceful man, Leroy went along quietly as he had always done. He was fined $20. An appeal was filed for him. After a trial *de novo* he was fined $50. There being no further provision for appeal under Texas law, the case went directly to the Supreme Court of the United States. (Certain cases recently decided in the United States Court of Appeals for the Fourth Circuit made it seem a good bet that Leroy would win in the Supreme Court.) However, on June 17, 1968, the Supreme Court affirmed his conviction. Hail Leroy Powell, born loser.

The defeat of Leroy Powell in Washington was the forerunner of victory in Annapolis. In anticipation of a reversal of the Powell case by the Supreme Court, Governor Agnew appointed a special commission to study the problem of the chronic alcoholic and to draft appropriate legislation to be introduced in the General Assembly. It consisted of representatives of the Medical and Chirurgical Faculty, the Maryland Bar Association, and the Attorney General. This tripartite committee, with a splendid assist from Father Harry E. Shelley, coordinator of alcoholism programs for the Baltimore City Health Department, drafted a bill which was approved by the Medical and Bar Associations and submitted to the legislature. It was the very last bill passed before the House of Delegates adjourned *sine die*. Signed into law by the Governor on April 10, 1968, Chapter 146 of the Laws of 1968, with the impressive title "Comprehensive Intoxication and Alcoholism Control Act," became effective July 1, 1968. In Chapter 146, the state has preempted the field of alcoholism legislation. Existing local law that is inconsistent with state law is declared null and void. Local legislation in the same area, whether or not supplementary to state law, is expressly prohibited.

It is too soon to have the benefit of judicial construction of this law. There have been no court cases so far. Our interpretation is offered with a cautionary note that if and when the courts are called upon to interpret the act they may or may not agree with some of the views we express here.

Preliminarily, the legislature found and declared that chronic alcoholics are sick people and it is wrong to deal with them as criminals; that mere public intoxication ought not to be a crime and,

Presented at a meeting of general hospital leadership personnel September 26, 1968, at the University of Maryland Center of Adult Education.

therefore, that a person found drunk in public, but not creating a disturbance or endangering the safety or property of another, ought to be taken into protective custody, or sent home or to a private or public health facility for detoxification and treatment; that a comprehensive, intelligent health program of prevention, care, treatment and rehabilitation is the answer to the problems of alcoholism, including the personality problems that go with drunkenness, and the diagnosis and treatment of other diseases that alcoholics are prone to contract; that handling chronic alcoholics through public health facilities is desirable because it relieves the police of the burden of dealing with such problems and allows them to concentrate on fighting crime, law enforcement and the maintenance of safe streets. And finally, it is stated to be the legislative intent that all public officials be made aware of the legislature's recognition that a chronic alcoholic is to be treated as sick and that the act should be construed in that light. In these findings and declaration of policy there is a rejection of traditional attitudes towards alcoholism and an approach to the problem that most people will concede to be enlightened and progressive, radiating hope and the promise of better times for the chronic alcoholic.

According to the new Maryland Alcoholism Law, a chronic alcoholic is any person who chronically and habitually uses alcoholic beverages to the extent that they injure his health or substantially interfere with his ability to function socially or in his job, or any person who drinks to such an extent that he has lost the power of self-control in his drinking.

The act creates the Division of Alcoholism Control within the State Department of Mental Hygiene to which is assigned the formidable task of implementing the law. It is clearly provided that ultimately the Division of Alcoholism Control will take over every function required for such implementation. This is consistent with the idea that alcoholism is a civil and not a criminal problem.

Before July 1, 1968, it was the law in Maryland that any person found drunk on the street or in a public place was guilty of a misdemeanor and subject to a fine and/or imprisonment. Habitual offenders, defined as persons convicted five times within the past year, could be fined up to $100 or imprisoned up to six months or both. These provisions were repealed and in their place was created a new crime called "disorderly intoxication," a misdemeanor that is committed when a person is intoxicated *and* endangers the safety of another person or property or when a person becomes intoxicated or drinks alcoholic beverages in public *and* causes a public disturbance. "Disorderly intoxication" is punishable by a fine of not more than $100 or imprisonment up to 90 days or both.

The 1968 General Assembly repealed and reenacted existing drunk laws not once but twice, the second time with some variations. The Legislature passed Chapter 666 which makes it a crime to do substantially the same thing as the conduct prohibited in Chapter 146. The penalties for violation of Chapter 666 are somewhat different and the habitual offender penalty is restored, but the only significant difference is that before a person may be charged with drinking and creating a public disturbance in violation of Chapter 666 he has to be warned first by a law enforcement official to stop drinking and creating a disturbance. If he ignores the warning he may be charged. It is a nice legal question as to which is the senior statute. Chapter 666 was signed into law almost a month later than Chapter 146 but whether that factor is controlling is open to question.

The role of the police under the new law is to extend help to persons in the acute stage of public intoxication. Fears have been expressed that the ending of arrests for public drunkenness will result in chronic alcoholics being left lying in the streets, and that when winter comes and the freezing weather combines with their affliction to create extra hazards for them, some helpless inebriates may literally freeze to death. It is an official duty of the police to help an alcoholic, now found drunk in public, no less than it was their duty to arrest him before July 1st. A memorandum recently distributed to all law enforcement agencies of the State by the Attorney General pointed out this duty in no uncertain terms. The admonition will be repeated as often as necessary. Until they are phased out, and their function taken over by authorized personnel under the direction of the Division of Alcoholism Control, the police are directed to carry out certain procedures upon finding a person drunk and incapacitated. An incapacitated inebriate is a drunk in a state of being unable to make a rational decision about accepting assistance.

The task of the police officer or other authorized personnel making the initial contact is to determine whether or not the inebriate has a home.

If he has, he should be sent home by commercial transportation, the officer being authorized to take reasonable measures in advance to see to it that the transportation is paid for. If the inebriate has no home it is the duty of the officer to send him to a health facility for detoxification. In cases of an emergency nature where detoxification or other treatment of the inebriate is immediately necessary to safeguard his health, even if he has a home he should be taken first to a health facility for treatment. Persons suffering from alcoholism who are to be charged with a crime but are in need of emergency treatment should likewise be brought first to a health facility. The basis for such action is that where the health of the individual is in immediate danger, priority is to be given to providing immediate medical treatment.

The first treatment of intoxicated persons is in the detoxification center. The law directs that every general hospital shall have a detoxification center although not necessarily a physical part of the hospital. The responsibility of general hospitals in this area is critical for if there are not enough detoxification units or the existing units are otherwise inadequate, the entire alcoholism program faces a dismal and uncertain future. The statute calls for detoxification units to be near population centers where they are needed most. The law directs that they be open 24 hours a day and that they provide their services without discrimination. These services should include medical services and also include examination, diagnosis and classification.

The ban on discrimination also prohibits discrimination on account of indigence, but payment for services rendered to solvent parties may be collected from the person treated or from responsible relatives. Also provided in the statute is for the State and local subdivisions to enter into contracts with any agency useful to the purposes of the program. This would appear to invite financial arrangements between government and institutions that provide necessary services.

In the case of an inebriate denied access to treatment in a general hospital or other health facility, the police officer, consistent with his duty to protect the health and safety of intoxicated persons, is required to take the inebriate into protective custody. Rejection by a hospital of alcoholics brought in for obviously necessary treatment, however, is likely to have a chilling effect upon police cooperation in the handling of inebriated persons. If the inebriate taken into protective custody is not involved in any criminal activity no criminal charge whatever is to be lodged against him nor an arrest record made nor any entry of a criminal record. When sober he is to be released forthwith.

We have indicated that an inebriate who has a home ordinarily should be sent home. In some cases detoxification at a private health facility may be in order. Private health facilities ought to be utilized whenever the circumstances are that the inebriate or his family can afford private treatment. Any relief for overburdened public facilities is to be welcomed and encouraged.

The determination of whether an inebriate who voluntarily applies should be admitted to the detoxification unit is the decision of the medical officer in charge. The physician in charge is authorized to require an inebriate admitted for treatment to remain for up to five days whether or not the patient wants to remain. If the physician decides that the inebriate should be treated at another facility the law directs that he arrange for such treatment and for transportation to the facility. If the intoxicated person is not admitted or referred to another facility and is without funds he should be offered a ride home, if he has a home, or if homeless efforts should be made to find him shelter. A detoxification center may treat medically a person not admitted as a patient. When such intoxicated person is admitted, however, the medical officer shall make a faithful effort to notify the family or next of kin unless the patient requests that this not be done. All records of the detoxification center are by law confidential; to be released only to authorized persons.

The act spells out the responsibilities of the general hospitals and their personnel. If the medical officer in charge determines that a patient should be admitted to the facility, the patient should be encouraged to consent to intensive diagnosis for possible alcoholism and for appropriate treatment. There is no restriction upon the number of admissions of the same person for treatment of alcoholism. The first admission should include a complete medical, social, occupational and family history as part of the diagnosis and classification, so says the statute. All available records bearing upon the patient's problem should be procured. A person diagnosed as not a chronic alcoholic

should be informed of the fact and efforts made to educate him in the seriousness of a drinking problem and the dangers of excessive intake of alcohol. Personal problems that are a factor in the patient's case should be investigated and referred to appropriate agencies for help if possible.

A patient diagnosed as a chronic alcoholic should be so informed and urged to consent to intensive treatment to begin immediately on an inpatient basis, and a comprehensive plan formulated for future treatment. The law prescribes that such plan is to be in writing and available to the patient. A voluntary patient may not be kept at the facility without his consent, but upon consenting to inpatient treatment, he is subject to any reasonable regulations that may be imposed by the facility. A patient leaving against medical advice may be readmitted at the discretion of the medical officer in charge. The fact of his leaving without permission may not preclude his readmission for that reason alone.

The act directs that outpatient treatment and after care are to be provided as needed by the patient. The statute contemplates the probability of one or more relapses by the alcoholic. Outpatient or other treatment may not be denied an individual solely by reason of a relapse or a number of relapses. For hopelessly chronic alcoholics who are not likely to improve, supportive services and residential facilities should be provided for their minimum decent comfort.

Except for the first five days of compulsory treatment of the incapacitated alcoholic that we spoke about earlier, these procedures that we have discussed involve treatment voluntarily applied for. Voluntary treatment is preferable says the act, but it also provides for commitment to an alcoholism facility. A judge at the circuit court level, a magistrate or substitute magistrate, a municipal court or people's court judge may order the alcoholic temporarily committed for care and treatment for a period of up to 30 days from the date of his admission to a detoxification unit. The petition for civil commitment in most cases may be filed by the commissioner of mental hygiene or someone designated by him. The petition must be filed and heard before the expiration of the first five days of detention in a detoxification unit. The order for commitment will be issued if the judge, sitting without a jury, decides that the person is a chronic alcoholic and that, as a result of chronic or acute intoxication, he is in immediate physical danger and unable to make a rational decision about accepting assistance. A person committed pursuant to such court order is to be released as soon as, in the judgment of the medical officer, he becomes able to make a rational decision about accepting assistance, unless such person voluntarily chooses to remain in the detoxification facility.

Persons committed under this procedure may write or otherwise communicate with outside sources without censorship, but reasonable regulations may be made with respect to visitation and the use of telephone and other communication facilities.

The statute also provides for criminal commitment of alcoholics. A person charged with a crime or convicted of a crime may be committed to a detoxification facility and required to take treatment for alcoholism in accordance with existing provisions with respect to probation and parole. In cases of chronic alcoholics found to be suffering from mental illness, the provisions of law respecting the mentally ill shall take precedence. However, where treatment for alcoholism is deemed desirable as part of the treatment for mental illness the law directs that such treatment be given.

Other provisions of the statute include the formulation of a highway safety program for drunk drivers and alcoholism programs for juveniles and for persons subject to the jurisdiction of the Department of Correction.

The Division of Alcoholism Control is charged, among other things, with the preparation of training and education programs, the preparation of statistics and reports and the dissemination of information and data to every conceivable agency concerned with the problem of alcoholism.

If any are singled out for special duty other than the Division of Alcoholism Control it is the general hospitals of the State. A commitment is asked of public and private segments of the community and of public and private health facilities but there is a strong current running through the act of reliance upon the general hospitals to provide the heavy weapons in the fight against alcoholism.

Success to Maryland's program could provide the answer to the conclusion of the Supreme Court in *Powell v. Texas* that in this day and age and for some time to come we have nothing better to offer the chronic alcoholic than jail. Several million reasonable facsimiles of Leroy Powell fervently hope the Maryland program will succeed. It could be their only hope.

your medical faculty at work

by John Sargeant
Executive Secretary

The Executive Committee met on October 10, 1968, and took the following actions:

1. Approved adjustments in various salary scales for classified employees.
2. Authorized attendance of one staff person at the annual convention of the Professional Convention Management Association and the Medical Exhibitors Association.
3. Authorized the Executive Secretary to arrange an appropriate early closing schedule for Christmas and New Year holidays.
4. Authorized the annual Christmas party for staff.
5. Approved dates for the 1969 Executive Committee and Council meetings.
6. Adopted policies with respect to use of the Faculty's Addressograph plates. This, primarily, reaffirms previous policy decisions that have been in existence for some time.
7. Adopted minutes of the September 5 and 6 House of Delegates meetings.
8. After consultation with the Woman's Auxiliary officers, adopted policies with respect to the extent of services provided the State Auxiliary by the Faculty.
9. Discussed the location of the Semiannual sessions and referred to the Program and Arrangements Committee the question of locating the Semiannual Meeting in September, 1969, 1970 and 1971, at a location with suitable accommodations.
10. Authorized expenditure of funds for the attendance of the Chairman, Subcommittee on Medicine and Religion at a regional conference to be held in New York City in March, 1969.
11. Authorized financial assistance for the wife and family of a physician who is ill and unable to work; and whose family is in need of such help.
12. Agreed to offer assistance to State Budget officials in connection with advice on health matters pending before that Bureau, if it so desires such help.
13. Set aside December 12, 1968, for a joint meeting with the Hospital Council Executive Committee.
14. Approved increasing honorariums for Annual and Semiannual Speakers from $100 to $150, at the request of the Program and Arrangements Committee.
15. Appropriated $500 for the Maryland Medical Political Action Committee to be used for educational purposes.
16. Authorized attendance of certain persons at the U. S. Department of Health, Education and Welfare's regional conference on Health Care Costs, to be held in Harrisburg, Pa., on December 10 and 11.
17. Took under advisement a request from the Subcommittee on Maternal Welfare for up to $100 for creation of a scientific exhibit on Perinatal Mortality.

(Continued next page)

18. Authorized up to $300 for the Subcommittee on Medical Aspects of Sports for a 1969 Seminar; with the understanding that exhibitors must be charged for exhibits at this session and appropriated funds used only if income from the exhibits does not cover costs of the Seminar.

19. Authorized the Public Relations Committee to establish "awards certificates" to be given through component societies to non-physicians for work in community health; and suggested that guidelines for the presentation, and criteria to be used in selecting the individuals be developed.

20. Referred to the Bylaws Committee the question of membership for Forty-year members who move from the State.

21. Submitted a list of names to the Governor for appointment to the Advisory Council on Hospital Construction, for selection of a replacement for F. Ford Loker, MD, who is deceased.

22. Authorized submission of the name of J. Arthur Weinberg, MD, for possible appointment as Medical Advisor to the State Accident Fund.

23. Approved preparation of a "draft" or "model" bill in connection with the Incorporation of Self-employed Persons, as outlined in Resolution 4A/68, adopted, as amended, at the Semi-annual session.

24. Authorized appointment of a three-man committee to work with Bendix Corporation officials in connection with a proposed Multiphasic Screening project.

25. Approved certain names offered by the AMA for possible appointment to various AMA Committees and Councils.

26. Authorized naming a three-man committee to look into and make recommendations in connection with policies involved in establishing principles in connection with admission of patients to coronary care units in hospitals.

27. Approved for submission to Blue Cross various names for appointment to the Blue Cross Physicians Review Committee.

28. Approved the principle of a Hearing and Vision Screening project for pre-school children, 3-5 years of age, on a state-wide basis; and requested the Subcommittee on Child Welfare to develop such a program for final approval.

29. Referred to the Subcommittee on Chronic Disease, the question of the Problem of Tuberculosis Control as suggested by the Baltimore City Medical Society. A report will be submitted for approval.

30. Approved mailing a letter to the Secretary of HEW protesting the cuts made in the program training of Radiation Therapy Technicians.



JERRY SALAN, MD, EDITOR

A Service of the Heart Association of Maryland

the heart page

Death: The Diagnostic Dilemma

As medicine progresses, the individual physician is often presented with additional developments which may pose moral, ethical, philosophical, technical, logistic, or religious considerations. All of these issues arise, for example, in discussing birth control, health control, and death control. Although the medical profession has been able to meet many of the material challenges related to the methodology of hemodialysis, open-heart surgery, organ transplantation, abortions, birth control, artificial maintenance of respiration and circulation, and clinical experimentation, too little consideration has been devoted to the ethical issue accompanying these developments.

LEONARD SCHERLIS, MD
Professor of Medicine
University of Maryland School of Medicine

In the recent past, it was relatively simple to define death when no effective measures could be employed to either delay or to prevent its occurrence. The recognition of death was straightforward: a mirror placed over the mouth would not cloud if breathing were absent. No effective means of intervention to delay or prevent death was available, and the mistaken diagnosis of death carried with it little, if any, real damage to the victim.

The diagnosis of death is conditioned by many factors, since death does not occur simultaneously to all organs, cells, or enzyme systems. If remnants of spiritual function were capable of assessment, the departure of the soul could be assumed to represent death. Descartes expressed his concept as: "I think, therefore, I am." Is such "thinking" to be equated with life, and the absence of cerebral function with death?

Is an individual "alive," who is maintained as a living preparation through such techniques as intravenous feedings, stomach tubes, urethral catheters, transfusions, artificial support of respiration, artificial support of circulation, renal dialysis, and the use of other mechanical devices or additional life support measures although there is no determinable brain function? Keith Simpson, MD, a London forensic pathologist has stated: "Tissues may be maintained in a living state both within the body and, by culture *in vitro,* outside. This is surely not being alive." Does death, rather, occur at that moment when the brain ceases to function?

These considerations are not alone of theoretical importance; they enter into our daily decision-making and therapeutic attempts. For example, in the field of cardiopulmonary resuscitation, there has been a general acceptance of criteria which have helped to guide the rescuer in determining when resuscitative efforts should be begun and when they should be terminated. The criteria for

recognizing cardiac arrest include the following: "unconsciousness, cessation of breathing movement, absence of carotid and femoral pulses, and death-like appearance." There had been an early awareness of the problems relating to clinical, as opposed to biological death. An individual may appear clinically dead, but may still be considered totally salvageable or retrievable despite a total lack of respiration and circulation for as long as five to ten minutes. Biological death occurs after this period of time has elapsed.

However, how does one define biological death? In a cardiopulmonary resuscitation setting, when should efforts for resuscitation be discontinued? The American Heart Association has defined this as a physician's responsibility in the following manner in its "Manual for Instructors": "Deep unconsciousness, absence of spontaneous respirations, and fixed dilated pupils for 15-30 minutes are indicative of cerebral death and further resuscitative efforts are usually futile. Cardiac death may be assumed when there is no return of electrocardiographic activity after one hour of continuous cardiopulmonary support." How long should efforts continue? Each instance is an individual problem with the decision made by the attending physician.

Our dilemma in arriving at a definition of death is directly attributable to our success in prolonging the functions of certain organ systems for long periods of time in a dying patient.

Must a physician utilize extraordinary as well as ordinary means to keep a patient alive? Pope Pius XII, in 1957, was asked when a doctor should stop artificial respiration to a patient who is virtually dead. He replied that the respirator and other systems for aiding circulation were extraordinary means of prolonging life and that the physician can give ordinary treatment but is not obligated to give extraordinary treatment. He further stated that human life continues for as long as its vital functions, distinguished from the simple life of the organs, manifest themselves without the help of artificial process.

As organ transplantation has developed, demands have increased for more sharply defined criteria for death. The success of an attempted transplant may be related to the time which elapses between the removal of an organ from the donor and its transplantation into the recipient. The cadaver can serve as a donor for only a few tissues; hence, the demand for organs from the living donors or from individuals immediately after death. The availability in a patient with irreversible brain damage of such usable organs as a heart, liver, and two kidneys may initiate a series of events leading to his circulation, respiration, and tissue perfusion being maintained until the necessary arrangements can be made with the selected recipient before the diagnosis of death is verified and life support measures interrupted. Can society afford to discard these organs? Or, and more pertinent, are the rights of the donor being adequately protected?

In many countries specified criteria are evolving, most of which advocate that the definition of death be ultimately based on "brain death," rather than the irreversible cessation of respiration and circulation. The determination of brain death may be established by such findings as the absence of reflexes and the registration of an isoelectric electroencephalogram, providing the conditions of hypothermia and the use of barbiturates and other depressants are not present. There is no agreement as to the duration of time during which the EEG should be isoelectric, the suggestions varying from one hour to days to "a long enough period." A "dying score" has been suggested with points given in evaluating cerebral function, reflex action, respiratory effect, circulation, and cardiac action. The evolving philosophy has been succinctly expressed by various individuals as, "A dead brain is a dead person," and "Life ends with the death of the brain."

Basic to all of these considerations is the importance of the protection of the rights of the potential donor. His personal physician should be concerned with the therapy of his patient as a patient, and not as a potential donor. Concern has been expressed that the latter approach may well lead to subtle changes in therapy not for the best interest of the patient. The Nuremberg Code and The Declaration of Helsinki are of significant value in providing codes of ethics for human experimentation. Similar "codes" may be of value in the area of transplantation.

The Church Assembly Board for Social Responsibility, in "Decisions About Life and Death," states, "Society cannot take the duty of decision away from the physician. It could not, without creating insurmountable practical difficulties, put it into commission by creating tribunals of some sort to decide the difficult cases . . . the doctor must be left with his decisions; but he must remain answerable for them to society; and the religious man would add, to God."

WILLIAM J. PEEPLES, MD, MPH, COMMISSIONER

Maryland State department of health

Highlights

Consumer Reactions to Medicaid Cutbacks

On July first, Medical Assistance was cancelled for approximately 22,000 individuals, and those still eligible but with income above Maryland's "indigency" level were required to meet part of their medical costs.

In the following three months, the Health Department received more than 1500 telephone calls and almost 100 letters from patients, their legislators, or others interceding in their behalf, while 432 patients appeared in person to plead for special consideration.

An additional 121 persons chose to carry their protest to the point of a formal appeal for fair hearing, as provided under Federal Law. In the process of obtaining records for these hearings, the Division of Social Work uncovered family conditions and illness problems revealing much hardship and suffering. Of the 121 appellants, 81 were no longer eligible for Medicaid and usually could see no way to continue under care. The remaining 40 had Medical Assistance cards, but could not make the required co-payments. Many of these patients had discontinued seeing their physicians or obtaining their medications.

Infection Control Conference Held

A conference on the Control of Infections in Hospitals, held October 16-17 in the auditorium of the Medical and Chirurgical Faculty, was attended by some 180 persons. Jointly conducted by the Maryland State Department of Health and the Maryland-D.C.-Delaware Hospital Association, the conference explored the infection problem from the standpoint of its magnitude and extent, standards for control, legal aspects, the hospital environment, isolation policies, microbiological aspects, the hospital laboratory, and interdisciplinary relationships.

The conference was held in cooperation with U.S. Department of Health, Education and Welfare, Public Health Service, Bureau of Disease Prevention and Environmental Control, National Communicable Disease Center, Atlanta, Georgia, and Bureau of Health Services, Division of Hospital and Medical Facilities, Silver Spring.

RMP Grant Requests

Three Health Department proposals have been included in the Operational Grant request, approved by the Maryland Regional Medical Program and recently forwarded to Washington for consideration. The request includes: Coordinated Discharge Planning Program for Wicomico and Somerset Counties, Stroke Rehabilitation Program at Deer's Head Hospital, and Rehabilitation Training Program for Community Hospital Nurses at Montebello. If approved by Washington, funding should be available in the late spring.

Other proposals involving the Health Department included two screening programs using the phonocardiscan and one program for multiphasic screening of school children in Baltimore city.

Possible Influenza Outbreak

Notice was received in August that an influenza-like illness had appeared in early July in Hong Kong where an estimated 15 to 30% of the population were attacked. A similar illness subsequently appeared in Singapore, the Philippines and other areas of Southeast Asia, increasing the likelihood that epidemics of this A2 type influenza

might occur in the U.S. during the '68-'69 season.

The previously developed influenza vaccines are not effective against this Hong Kong virus. However, because of the possibility that B type influenza epidemics might also occur this season, use of existing vaccines was recommended for persons in the high risk groups. A vaccine against the A2/HK/68 virus is now in process of development. Its output will necessarily be limited and its use should be confined to high risk groups.

Lead Poisoning Surveillance

In the 1968 Fiscal Year the Baltimore City Branch Laboratory of the Bureau of Laboratories made almost 1500 examinations of blood for lead as an aid in the diagnosis and treatment of lead poisoning. Abnormal amounts of lead were found in specimens from 36 children. In addition, 967 samples of paint scrapings were examined and 46% contained in excess of 1% of lead, the maximum amount permitted in interior paint by Baltimore City Ordinance and Regulation. One case each was reported from Howard, Caroline, and Baltimore Counties.

Laboratory Evaluation Committee Appointed

An ad hoc Laboratory Evaluation Committee has been appointed by the Maryland Society of Pathologists, to assist the Bureau of Laboratories when a specific survey requires special determination not provided by the Department. This Committee consists of the following Board Certified Pathologists: Robert G. Lancaster, MD, Chairman; John V. Petrucci, MD, and Peter W. Rieckert, MD.

Cervical Cytologic Examinations Increase 19.6% in Calendar Year 1967

Cytologic Examinations	CY 1966	CY 1967
Hospitals	122,772	137,724
Private Laboratories	212,169	294,915
Subtotal	334,941	432,639
Bureau of Laboratories	44,868	22,965
Grand Total	379,809	455,604

(These figures do not include self-administered irrigation technique tests.) The overall increase in 1967 amounts to 75,795 examinations, or 19.6%.

Funds Restored for Local Health Services

The budgetary restrictions imposed on the Health Department for fiscal year 1969 meant to many local health departments eliminating or curtailing a number of clinical services, and in virtually all areas postponing the planned expansion of services. A detailed report of the impact on individual health departments was sent to Governor Agnew September 27.

On October 12 the Governor's office announced that slightly more than $1 million would be restored for general local health services, permitting many clinics to resume planned operations.

The restoration of funds for clinic services has considerably brightened the prospects for health care of Maryland's citizens, especially in the counties which depend largely on State funds for their operations.

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DOUGLAS G. CARROLL, MD, EDITOR

rehabilitation notes

Measurement of Performance in Rehabilitation*

APPLICATION OF METHOD

"The external world . . . if it exists . . . consists of events, short, small and haphazard. Order, unity, and continuity are human inventions just as truly as are catalogues and encyclopedias. But human inventions can, within limits, be made to prevail in our human world, and in the conduct of our daily life we may with advantage forget the realm of chaos and old night by which we are perhaps surrounded." [1]

* * * * *

It has been possible by use of the methods described before to correlate a large mass of data in an attempt to identify which of the original findings are most often associated with improvement in ADL scores and which items were most often associated with deterioration in function. Once various items are identified as having a correlation with improvement or deterioration, it will be possible to ask why and how these items are important. These observations have been made on all adult (over age 15) inpatients referred to the Department of Physical Medicine and Rehabilitation since 1957.

The patient is treated as an experiment in nature with measurements before and after treatment. The results of treatment are evaluated in the light of initial measurements. At the time of discharge, the patients were divided into three groups, those who showed improvement in activities of daily living, those who showed no improvement and those who deteriorated while under treatment. Improvement in ADL score was defined as an increase in ADL score sufficient to place the patient in a higher score group.◆ The least the total score could increase was 5 points in a patient classified as improved. Deterioration in ADL score was defined as a drop in score group of one or more. Those patients who had unchanged ADL scores remained in the same score group before and after treatment. These three groups were then compared to see if there were differences in the initial classifications and measurements which were correlated with deterioration, improvement or no change in ADL. Table 1 is the form used for recording initial and follow-up data.

Since 1957 nine different series of patients have been studied. The total number of patients studied is 3,148.

* This is the eighth of a series of notes on "Rehabilitation of Chronic Impairments in Adults."

◆ The ADL score groups are 0-20, 21-40, 41-60, 61-80, 81-95, and 96-100. Recently we have subdivided the improved group into three parts: those who reached full independence (ADL Score 100), those who reached ADL score of 90 to 99 and those who improved, but did not reach 90 or above.

The following tables are made up from different series studied, and, therefore, the number of patients in each group may be different. The studies were performed on patients seen serially in the Department of Physical Medicine and Rehabilitation without any attempt to separate them into diagnostic groups.

Results

Table 2 shows that sex and color made no difference in the final result measured by ADL score (A). Patients who had sudden onset of their impairment improved more often than those who had slower onset (B). Those with expected normal life expectancy performed better than those who had reduced life expectancy (C). Patients with very low initial ADL scores showed less improvement than those with higher scores. Above the ADL score group 46-85, there was a drop off in the number improving in ADL score (D).

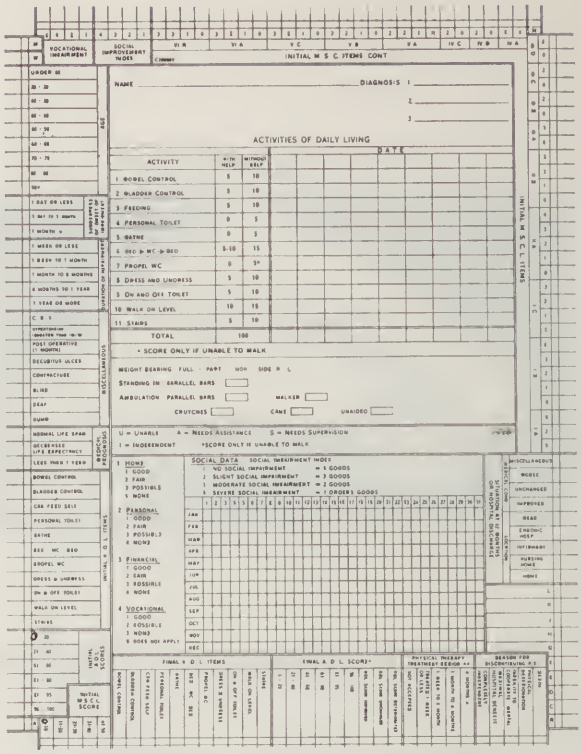


Table 1: Card used to record all data collected on each patient.

Table 2

	Total	Final: Improved ADL Score %	Final: Unchanged ADL Score %	Final: Deteriorated ADL Score %
A) **Male**	167	56	43	1
Female	133	53	43	4
White	194	54	44	2
Non-White	106	56	40	4
Total	600			
B) ***Suddenness of Onset of Impairment:***				
1 day or less	181	63	36	1
Greater than 1 day	119	42	52	6
Total	300			
C) ***Predicted Medical Prognosis when first seen in Department of P.M. & Rehab.:***				
Normal Life Expectancy	149	66	32	2
Reduced Life Expectancy	274	38	54	8
Life Expectancy less than 1 year	129	12	65	23
Total	552			
D) ***Initial ADL Score Group***				
0-10	100	14	74	12
11-25	149	30	56	14
26-45	176	55	35	10
46-85	224	69	28	3
86-95	66	52	41	7
96-100	85	7	93	0
Total	800			
E) ***Initial MSCL Score***				
0-10	132	12	65	23
11-20	66	27	58	15
21-30	98	45	42	13
31-40	138	40	51	9
41-50	177	44	50	6
Total	611			

Results at end of treatment in Department of Physical Medicine and Rehabilitation in patients with different initial findings.

Patients with initial MSCL scores below 21 had a lower percentage of improvement in ADL score than those with MSCL scores 21 or greater (E).

Table 3 shows that the longer the duration of the impairment the smaller the percent of patients who improved in ADL score (A).

Patients were divided into different diagnostic groups with the results indicated in B. These diagnostic groups represent the major disease from which the patient suffered. Since this study, the diagnostic categories have been defined more accurately.

Patients younger than 20 improved in the great majority of cases. Those between 20 and 69 did fairly well, while those older than 69 improved a smaller percentage (C).

Table 3

	Percent of Patients Improving in ADL Score
A) Duration of Impairment (300 patients)	
1 week or less	68
1 week to 1 month	58
1 month to 6 months	54
6 months to 1 year	50
1 year or more	44
B) Diagnostic Group (911 patients)	
Musculo-skeletal	65
Peripheral Vascular	60
Neurological	33
Cardiac	32
Collagen Disease	32
Respiratory	30
Cerebrovascular	23
Endocrine	20
Mental	18
Gastro-intestinal	18
Genito-urinary	17
C) Age (911 patients)	
Below 20	69
20-29	40
30-39	38
40-49	49
50-59	49
60-69	40
70-79	29
80-89	28
90+	25

Percent of patients who improved in relation to duration of impairments, diagnosis and age.

Discussion

The above studies suggest that sex and color make little difference in predicting whether a patient will improve under treatment in our Department of Physical Medicine and Rehabilitation.

From this study (Tables 2 and 3) one would expect that the patient who is most likely to improve in ADL score while being treated in our Department of Physical Medicine and Rehabilitation is under 20 (69% improved in ADL score), has an initial ADL score between 46 and 85 (69% improved), incurred the impairment less than a week before being seen in the Department (68% improved), has a normal life expectancy (66% improved), has a musculo-skeletal impairment (65% improved), and has a MSCL score over 21 (over 40% improved).

Although these data are of some general help in selecting patients who will benefit from treatment in our Department of Physical Medicine and Rehabilitation, the question immediately arises as to how these data can be used to predict more accurately which individual patients will improve. Secondly, why are these initial characteristics important for improvement. A number of hypotheses came to mind to explain them. It is obvious immediately, however, that the diagnostic criteria are too general and that we have not identified the presence or absence of associated diseases. For this reason the diagnostic system in a previous article [2] was developed. It differentiates between patients with one and multiple diseases, impairments or syndrome. It is necessary to develop prognostic criteria for each of these diagnostic groups. Only when patients with similar underlying diseases are compared will it be possible to develop prognostic criteria.

An additional question is the relative importance of each initial characteristic in predicting the final result. It is possible that some of these questions can be answered by statistical analysis of data collected on similar patients. Future articles will deal with the rehabilitation of patients with specific impairments, diagnoses and syndromes, methods of predictions and outcome of rehabilitation from data collected during the initial evaluation.

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ROBERT E. FARBER, MD, MPH, COMMISSIONER

Baltimore City health department

Psychiatric Day Center

The Psychiatric Day Center of the City Health Department, a pioneer effort in Maryland and throughout the country, has completed six successful years of service to city residents.

As a result of its successful performance, the Psychiatric Day Center has moved from its former location at 2111 North Charles Street to 2708 North Charles Street where it will join the North Charles General Hospital Complex, and become the first of a series of units which will constitute a new Comprehensive Community Mental Health Center serving the north central area of the city.

The new comprehensive center will come about as the result of the cooperation of four agencies: the Baltimore City Health Department, the Maryland State Department of Mental Hygiene, Springfield State Mental Hospital and the North Charles General Hospital. On January 1, 1969, the Springfield State Mental Hospital Outpatient Clinic will move to the new Complex. Within the near future a facility will be built, architecturally designed to accommodate a psychiatric day hospital, outpatient clinics, emergency care, an alcoholism center, and an evaluation and counseling unit for elderly persons.

At the present time the Psychiatric Day Center is available to receive city adult residents who would, in its absence, require hospitalization for emotional illness. Patients discharged from the Day Center are then treated as outpatients, receiving chemotherapy as required. At the North Charles General Hospital, a small number of inpatient beds are available to provide crisis care for Day Center patients. The hospital is also available to adults from the community requiring outpatient care. The Springfield State Mental Hospital outpatient clinic will provide continuing care to patients discharged from the State Hospital.

In order to provide increased psychiatric staffing at the new location of the Day Center, it is a pleasure to report that DeWitt L. Weatherly, MD, has assumed full-time duties as Associate Director, effective October 1, 1968. He will assist Gertrude M. Gross, MD, Director, in the care of patients at the Day Center and will be responsible for development of the Comprehensive Mental Health Center in collaboration with Addison W. Pope, MD, Regional Director of Mental Health for the State Department of Mental Hygiene.

In addition to the comprehensive mental health center being developed at the North Charles General Hospital, similar centers are under development at Sinai Hospital, University of Maryland Hospital, The Johns Hopkins Hospital and at the Baltimore City Hospitals. The creation and development of these community centers will serve to change dramatically the manner in which psychiatric care can be rendered to city residents.



JAMES E. CARSON, MD, COMMISSIONER
KURT GORWITZ, ScD, STATISTICS DIRECTOR

Maryland State department of mental hygiene

Employee-Patient Ratios

The ratio of employees to patients in Maryland's four regional psychiatric hospitals* has more than doubled since 1950. As shown in the following table, this change has been caused mainly by an increase in the number of employees. The average size of the patient population in these hospitals, which increased until 1955, has since declined to slightly below the level of 1950.

FISCAL YEAR	AUTHORIZED POSITIONS	AVERAGE SIZE OF PATIENT POPULATION	AUTHORIZED EMPLOYEES PER 100 PATIENTS
1950	1,719	7,844	21.9
1960	3,225	8,516	37.9
1964	3,553	7,821	45.4
1966	3,784	7,825	48.4
1967	3,986	7,730	51.6
1968	4,188	7,435	56.3

This rising employee-patient ratio is primarily related to a continuing change in the composition of the patient population resulting from a six-fold increase in admissions (from 1,953 in 1950 to 11,512 in 1968) and a nine-fold increase in live releases (from 1,233 in 1950 to 10,970 in 1968). Eighteen years ago 65% of all patients had been hospitalized five years or more, 20% had been under care between one and five years and the remaining 15% were hospitalized less than one year. These percentages are now 45, 25 and 30 respectively. Patients hospitalized for the short-term treatment of acute disturbances require much greater staff services than do chronic patients hospitalized for extended time periods.

Latest available national statistics (for 1967) provide some indication on the relationship of employee-patient ratios to patient turnover and release rates. Arkansas, Colorado and Nebraska (with 76.4, 105.1 and 83.3 employees per 100 patients, respectively) all had more live releases than admissions. The average size of their patient population decreased 53.9, 53.7 and 23.1% in the last five years. Alabama, Florida and Virginia (with 27.5, 47.7 and 37.4 employees per 100 patients, respectively) all had more admissions than releases—the only states with a reported patient population increase during this five-year period.

It should be recognized that data on authorized staff can be deceptive since they do not take into account vacant positions. On June 30, 1968, 409 of the 4,188 authorized positions were vacant so that the ratio of employees to patients was reduced from 56.3 to 50.8%. Further, more than four employees are required to fill one position on a 24-hour a day, seven days a week basis and many staff members are not directly involved in inpatient treatment. For example, one-third of the department's psychiatrists are either engaged in an administrative capacity or in the treatment of patients on an outpatient basis. Thus, many hospital areas, particularly in chronic, long-term wards, continue to have minimal employee-patient ratios.

Available data indicate that the number of admissions to these hospitals will continue to increase 10% or more per year. This can be expected to produce a gradual rise in the proportion of beds occupied by acutely ill patients receiving short-term treatment. Based on these facts, a continuing increase in employee-patient ratios is imperative to maintain present levels of services.

* Crownsville, Eastern Shore, Springfield and Spring Grove hospitals.

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MRS. HARRY L. BERMAN, EDITOR

Fall Conference in Chicago

At Chicago's Fall Conference state auxiliary presidents and presidents-elect had their chance to hear national chairmen and officers spell out their emphasis for the year and get material to pass on to state chairmen and county units.

The conference opened Monday, Sept. 30, with a keynote address by Ernest B. Howard, MD, AMA acting executive vice-president. Herbert A. Raskin, MD, clinical associate professor, Department of Psychiatry, Wayne State University (Detroit), spoke on the subject, "The Use and Abuse of Alcohol and Drugs by Today's Youth," and Joseph B. Trainer, MD, associate professor of physiology and medicine, University of Oregon Medical School, dealt with the subject, "Some Special Characteristics of the Physician's Family". Presentations by national committees on children, youth and home-centered health-care were also on the morning's schedule.

Dwight L. Wilbur, MD, President of the AMA, spoke at Monday's luncheon on "Medical Manpower." Following, speakers were: William B. Walsh, MD, president and medical director of "Project Hope", and George W. Beadle, PhD, director, AMA Institute for Biomedical Research.

Conference members were invited to a dinner sponsored by the American Medical Political Action Committee. Mrs. Shirley Temple Black, newly returned from Czechoslovakia, was the speaker.

State presidents and presidents-elect attended the "Seminar on Public Speaking" Tuesday. Panelists and instructors were Roy Wood, PhD, associate dean of the school of speech, Northwestern University; Mortimer T. Enright, coordinator, AMA Speakers Program; and Edward A. Uzemack, director, AMA Officers Service Department. The seminar featured public speaking fundamentals with live TV playbacks, a manuscript reading drill, rehearsal of live speech presentations with critique and taping of improved speeches and playback over TV monitors. Twelve volunteers were selected for active participation while the audience observed and listened.

Also on Tuesday morning the auxiliary communication committee conducted a session on "Writing Pointers" especially for national officers, directors and committee chairmen. There was a glimpse of "Behind the Scenes with *MD's Wife*" presented by the editor and art director of the magazine. The AMA-ERF committee of the auxiliary presented Tuesday's luncheon program. Tuesday afternoon speakers were Mrs. D. Ann Sparmacher, RN, secretary, AMA Committee on Nursing; and Mrs. Sue Boe, consumer information specialist, Pharmaceutical Manufacturers Association. Presentations by the national auxiliary's parliamentarian, the committee on legislation and the communications committee were also on the agenda—obviously full and very constructive.

Regional Workshops

Four regional workshops were conducted in October for leaders of state auxiliaries. This is the fourth year for the workshops which have proved to be one of the national auxiliary's most popular and worthwhile communications efforts. Six women from each state—five chairmen plus the state president-elect—were invited to the two-day

meeting. The chairmen represented the state committees on AMA-ERF, health careers, mental health, safety-disaster preparedness and community health. Our president also attended. A traveling team of national officers and committee chairmen led the sessions in Denver, New Orleans, St. Louis and Boston. Our own region met in Boston, October 17-18.



State Board members at work during a fall meeting conducted by Med-Chi Auxiliary President, Mrs. Leonard Warres (right, front).

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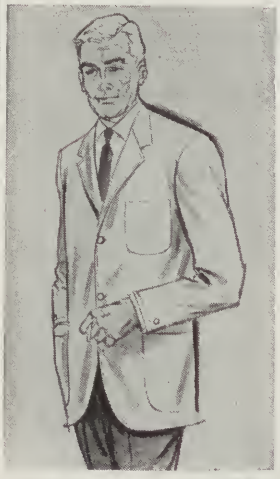
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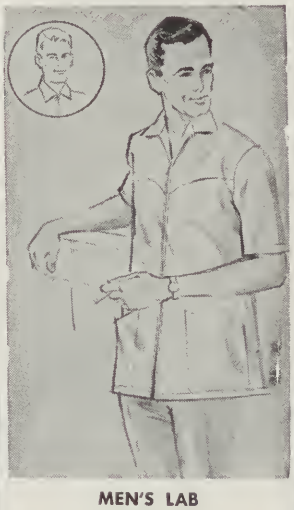
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Sir William Osler.
***Aequanimitas:* "Books and Men."**

Following the recent article on the LIBRARY PAGE by Dr. John De Hoff, we wonder how many physicians were reminded that the Medical and Chirurgical Faculty Library privileges comprise an important part of the continuing education of Maryland physicians. The above quote from Osler's book points this up very effectively, and seems even more true now that technology and the generation of medical information is advancing so rapidly.

How can the practicing physician get what he wants from the library? How can he find time from his busy office practice to visit the library for browsing and research on his special problems? In an emergency, how can he obtain information without a personal visit to the library?

To answer these questions, there are several ways in which any member physician may request information. The best method, of course, is an actual visit to the library where you may peruse the card catalog, explore the new books and journals and, most important, become acquainted with the librarian and other staff members, who can best assist you after personally discussing your informational problems.

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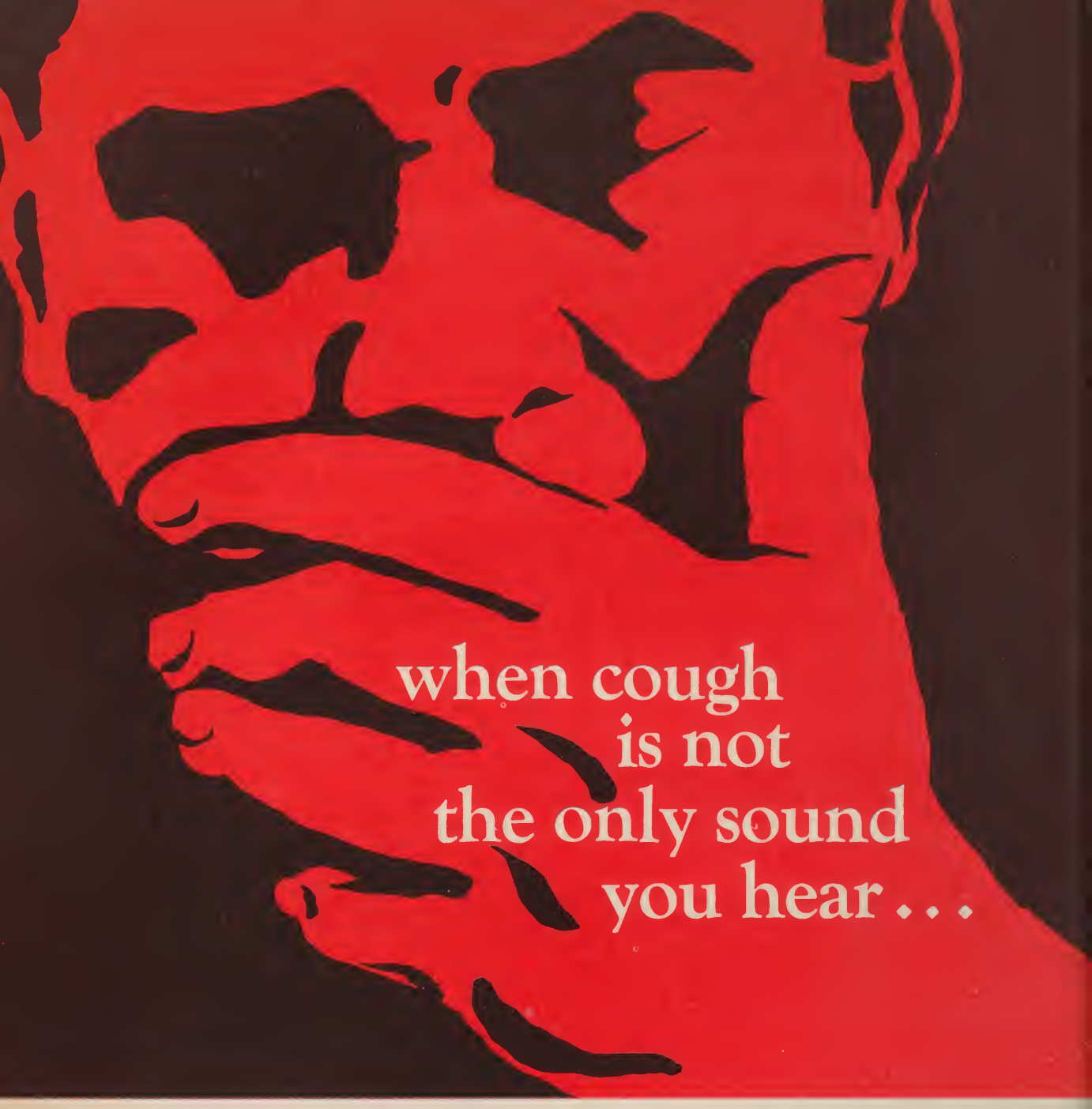
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Staphylococcus aureus

# OF CULTURES	YEAR	% EFFECTIVE
6,723	1962	88.6%
5,435	1963	88.0%
10,384	1964	88.5%

References: 1. Fowler, J. Ralph et al. Clinical Medicine **70** 547 (Mar.) 1963 2. Isenberg, Henry D.: Health Laboratory Science **1** 185-256 (July-Aug.) 1964 3. Isenberg, Henry D. Health Laboratory Science **2** 163-173 (July) 1965.

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Beer and Heart Disease

Increasing evidence of serious heart disease among chronic beer drinkers is the basis of a research program at the University of Minnesota.

A grant to support the study has been announced jointly by Stanley F. Yolles, MD, Director, National Institute of Mental Health, and Malcolm C. Moos, President of the University.

According to Dr. Carl S. Alexander, principal investigator, 85-90% of the patients at the Minneapolis Veterans Hospital with primary myocardial disease are chronic beer drinkers, and most of these patients develop alcoholic heart failure.

Major aims of the research, according to Dr. Alexander, are to see if alcohol 1) produces a depletion of necessary elements found in the heart, such as magnesium, potassium and zinc; 2) changes the level of protein, actomyosin and collagen in the heart; and 3) affects heart muscle in other ways.

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Chiropractic Approach

Chiropractic—despite some practitioners' efforts to draw closer to medical science—takes an unscientific approach to causes and cures of diseases, it was reported at the Fourth National Congress on Health Quackery.

"To date," said Hugh H. Hussey, MD, director of the American Medical Association's Division of Scientific Activities, "the brotherhoods of chiropractic have talked about causes and cures of diseases as they relate to vertebral subluxations.

"Some of the talk uses words derived from sciences, but none of it has developed from the scientific method."

As recently as June, Dr. Hussey said, AMA's House of Delegates reaffirmed an earlier statement on the subject:

"It is the position of the medical profession that chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease.

"Chiropractic constitutes a hazard to rational health care in the United States because of the substandard and unscientific education of its practitioners and their rigid adherence to an unscientific approach to disease causation."

Medicine, unlike quackery and cultism, is now founded in the scientific method, Dr. Hussey said: "That method begins with a hypothesis that usually has arisen from previous observations. Then data are collected systematically in the expectation that they may support the hypothesis. Finally, by analysis of the data a decision is made that the hypothesis is supported, or refuted, or that more data are needed."

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If the chiropractor sometimes seems better able than the physician to satisfy a patient, Dr. Hussey said, salesmanship may be involved: "He (the chiropractor) tells his patients what he believes they want to hear and, further, that his methods are just what the patients need—that nothing else will do.

"Unlike the physician, he never says, 'Let it alone and it will get better,' or, 'Take two aspirin tablets, stay quiet, and call me tomorrow.' The chiropractor attracts the ignorant, the fearful, and the dissatisfied neurotic."

Theoretically, the chiropractor would lose most of his clientele if the public were universally sophisticated and physicians ever mindful of their art, Dr. Hussey said, but there always will be gullible persons.

Health education of the public suffers setbacks when any form of quackery acquires an aura of respectability or appears to effect cures, he said, explaining:

"Sometimes the aura of respectability results from a prominent person's favoring ministrations of a cultist above those of a physician, or when lawmakers license the cultist.

"Or, because most human ills are self-limited, the cultist can claim 'cures.' When the illness is more severe," Dr. Hussey said, "I daresay they (the cultist's clients) seek other care. But then it may be too late."

Before assuming the AMA post, Dr. Hussey was dean of the Georgetown University School of Medicine, Washington, D. C.

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Quackery Is Worldwide Threat,

AMA President-Elect Warns

Health quackery is an international disease that "menaces the public health" and must be wiped out, Gerald D. Dorman, MD, president-elect of the American Medical Association, said recently.

Dr. Dorman, speaking at the Fourth National Congress on Health Quackery at the Drake Hotel, noted that the "international health quack, like his counterpart in this country, uses or promotes unorthodox methods of diagnosis and treatment of human disease. . . . " These, he said, "do not meet the rigid requirements of the world's scientific community in regard to objective proof of efficacy and safety.

"Americans are spending large sums of money on health quackery in such far away places as the Philippine Islands . . . and in our border neighbors of Canada and Mexico," Dr. Dorman told members of the congress, which is sponsored by the AMA and the National Health Council.

Dr. Dorman pointed to a Filipino named Antonio Agpaoa, or "Dr. Tony" as he is called, a "former sleight-of-hand artist who claims he can do abdominal, heart and even brain surgery with his bare hands, without benefit of anesthesia or aseptic procedure." Dr. Dorman noted that Agpaoa's education stopped at the third grade.

Planeloads of Americans have flown to the Philippines to seek "psychic surgery" from Agpaoa, and "Dr. Tony" has been highly promoted in the United States.

But the AMA urged Philippine authorities to take action, and "Dr. Tony" now is under a provincial court injunction.

"In the other direction, across the Atlantic Ocean," Dr. Dorman said, "there are the 'rejuvenators' who will 'make you young again' or revitalize a 'worn out' organ of your body.

"Much closer to home," Dr. Dorman said, "you need only to cross the border in lower California at Tijuana to find doctors of medicine, nurses and others offering so-called cures for cancer, arthritis, mental retardation and other disease categories."

Dr. Dorman said the AMA and other concerned health organizations have taken action to stop this international victimizing of sick Americans. But he added that "law enforcement attitudes vary from country to country . . . and what is really needed is a vast educational campaign" to let the public know the best health care is in the United States and to keep sick persons from wasting their money on quacks "beyond our borders."



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Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.



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Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

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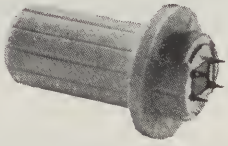
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PRECAUTIONS: (1) Desipramine hydrochloride should not be substituted for hospitalization when risk of suicide or homicide is considered grave. Suicidal ingestion of large doses may be fatal. (2) If serious adverse effects occur, reduce dosage or alter treatment. (3) In patients with manic-depressive illness a hypomanic state may be induced. (4) Discontinue drug as soon as possible prior to elective surgery.

ADVERSE EFFECTS: The following side effects have been encountered: dry mouth, constipation, dizziness, palpitation, delayed urination, agitation and stimulation ("jumpiness," "nervousness," "anxiety," "insomnia"), bad taste, sensory illusion, tinnitus, sweating, drowsiness, headache, hypotension (orthostatic), flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, tremor, allergy (general), altered liver function, ataxia and extrapyramidal signs, agranulocytosis.

Additional side effects more recently reported include: seizures, eosinophilia, confusional states with hallucinations, purpura, photosensitivity, galactorrhea, gynecomastia, and impotence. Side effects which could occur (analogy to related drugs) include weight gain, heartburn, anorexia, and hand and arm paresthesias.

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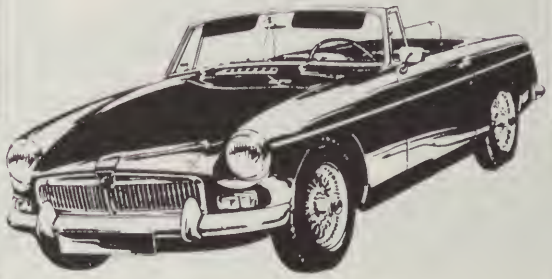
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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

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